Re: Public Comment Submission -- PROVIDENCE HEALTH PLAN Rate Increase Request

This is to provide public comment on Providence Health Plans’ requested Rate Increase of 15.7% on its’ individual plans. I am writing to follow up on the testimony by Shane Jackson, lobbyist for the Autism Society of Oregon, at the hearing on August 3, 2012.

I OPPOSE the requested rate increase. As described by Shane, Providence’s contracts contain illegal provisions that have been improperly used to deny lawfully mandated coverage for treatment of autism and other developmental disabilities. Since the “benefits” in the contract violate Oregon and Federal law, I ask the Insurance Division to determine that these (illegal) “benefits ... are not reasonable in relation to the premium charged.”

For reference, I have attached the following:

- Providence Health Insurance Contract Clauses Violating Oregon / Federal Law: description of 6 clauses in Providence’s contracts that violate state and federal law [Note: this is a revision of the Exhibit A submitted by Shane on 8/3/12, and identifies two additional clauses violating state and federal law]
- Denial letter of July 24, 2012: a redacted denial letter that Providence sent to a consumer, denying lawfully mandated coverage of autism on the basis of illegal contract terms
- Providence Oregon Group Member Handbook: sample contract illustrating illegal language
- Your Benefit Summary: sample benefit summary illustrating illegal language

Note that while the contracts I have analyzed are not the same as the one under consideration for this rate review, and that not all laws I have identified apply to this particular plan, the problem is pervasive and I urge you to deny the rate increase until Providence has taken meaningful steps to bring itself into compliance on all of its’ contracts.

Sincerely,

Paul Terdal
Providence Health Insurance Contract Clauses Violating Oregon / Federal Law

Introduction
Providence Health Plan has issued Group Member Handbooks (contracts) that violate Oregon and Federal laws requiring coverage of developmental disabilities. Providence has aggressively interpreted these clauses to illegally deny coverage of conditions, such as autism spectrum disorders, despite a clear statutory mandate for coverage.

This document is based on a review of the Providence Health Plan, OREGON GROUP MEMBER HANDBOOK FOR PERSONAL OPTION PLANS, PGC-OR 0811 EPO PERSONAL HBK, HBK-024G, for 2012, along with the accompanying Benefit Summary (PGC-OR 1008 SG PED1). A review of member handbooks for other Providence plans indicates that contractual language is similar.

Summary of Providence Contract Clauses Violating Oregon / Federal Law

<table>
<thead>
<tr>
<th>Providence Member Handbook Clause:</th>
<th>Violations of Oregon / Federal Law:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusions that apply to Mental Health and Chemical Dependency Services: (page 45) Services related to developmental disabilities, developmental delays or learning disabilities including, but not limited to, education Services. A learning disability is a condition where there is meaningful difference between a child’s current academic function and the level expected for a child that age. Educational Services include, but are not limited to, language and speech training, reading, and psychological and visual integration training as defined by the American Academy of Pediatrics Policy Statement - “Learning Disabilities, Dyslexia and Vision: A Subject Review”;</td>
<td>• ORS 743A.168 (Mental Health Parity) o Requires “coverage for expenses arising from treatment” for mental health conditions, including autism • ORS 743A.190 (Children with pervasive developmental disorder.) o Requires coverage of “all medical services ... that are medically necessary and are otherwise covered under the plan” for “Asperger’s syndrome, autism, developmental delay, developmental disability or mental retardation” • Comments: o Providence has interpreted this clause to exclude ALL services for developmental disabilities, not just “education services” and has used it to deny coverage of mental health services for autism</td>
</tr>
<tr>
<td>Exclusions that apply to Mental Health and Chemical Dependency Services: (page 45) Speech therapy, physical therapy and occupational therapy Services provided in connection with treatment of psychosocial speech delay, learning disorders, including mental retardation and motor skill disorders, and educational speech delay including delayed language development (except as provided in sections 5.4.3. and 5.9.3);</td>
<td>• ORS 743A.190 (Children with pervasive developmental disorder.) o Requires coverage of “all medical services, including” physical therapy, occupational therapy or speech therapy services “that are medically necessary and are otherwise covered under the plan” for “Asperger’s syndrome, autism, developmental delay, developmental disability or mental retardation”</td>
</tr>
</tbody>
</table>
## Providence Member Handbook Clause:

**General Exclusions** *(page 43)*  
We do not cover Services and supplies which:  
Are provided in an institution that specializes in treatment of developmental disabilities;  

### Violations of Oregon / Federal Law:

- **ORS 743A.010** (Services provided by state hospital or state approved program)  
  - Prohibits exclusion of “state approved … community developmental disabilities program”

- **ORS 743A.168** (Mental Health Parity)  
  - Prohibits limitations that are more “more restrictive than those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions.”

- **ORS 743A.190** (Children with pervasive developmental disorder.)  
  - Requires coverage of “all medical services” for developmental disabilities “that are medically necessary and are otherwise covered”

### Qualified Practitioner *(page 94)*  
Qualified Practitioner means a physician, Women’s Health Care Provider, nurse practitioner, nurse practitioner midwife, clinical social worker, physician assistant, psychologist, dentist, or other practitioner who is professionally licensed by the appropriate governmental agency to diagnose or treat an injury or illness and who provides Covered Services within the scope of that license.

#### Violations of Oregon / Federal Law:

- **ORS 743A.168** (Mental Health Parity)  
  - Specifies that “a provider is eligible for reimbursement” of mental health services if the provider “is providing a covered benefit under the policy” or has been “approved by the Department of Human Services” – even if not professionally licensed.

### Hospital Services *(Benefit Summary, page 2)*  
- Rehabilitative care (30 days per calendar year)

### Other Covered Services *(Benefit Summary, page 3)*  
- Outpatient rehabilitative services (30 visits per calendar year)

#### Violations of Oregon / Federal Law:

- **Wellstone / Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)**  
  - Specifies that “the treatment limitations applicable to such mental health … benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan….”

Under MHPAEA, comparison standard for mental health parity is to the “treatment limitation across the board to all therapies related to medical and surgical services” – NOT to treatment limitations imposed on similar rehabilitative therapies for medical and surgical conditions. *(Z.D. v Group Health Cooperative, U.S. District Court for the Western District of Washington, Case No. C11-1119RLJ. June 1, 2012)*

### 9.2.4. External Review *(page 57)*:  
“By electing to submit your appeal to an IRO, you are also agreeing to be bound by and to comply with the IRO decision regarding your appeal in lieu of appealing to a state or federal court.”

#### Violations of Oregon / Federal Law:

- **ORS 743.857, 743.859, 743.863, 743.864**  
  - Specify right of insured to external review, and impose civil penalties on insurers who fail to comply with IRO decision, but don’t require enrollee to comply in lieu of appeal to a state or federal court.
Detailed Explanation of Providence Contract Violations of Oregon or Federal Law

Introduction
This section reviews each of the six clauses in Providence’s contract that violate Oregon or Federal law.

Clause: Exclusion of Developmental Disabilities

Text of Providence Contract:

7. EXCLUSIONS:
Exclusions that apply to Mental Health and Chemical Dependency Services: (page 45)
“Services related to developmental disabilities, developmental delays or learning disabilities including, but not limited to, education Services. A learning disability is a condition where there is meaningful difference between a child’s current academic function and the level expected for a child that age. Educational Services include, but are not limited to, language and speech training, reading, and psychological and visual integration training as defined by the American Academy of Pediatrics Policy Statement – ‘Learning Disabilities, Dyslexia and Vision: A Subject Review’”

Violations of Oregon Law:
Providence has interpreted this clause to exclude ALL services for developmental disabilities, not just “education services” and has used it to deny coverage of mental health services for autism. This clause violates both ORS 743A.168 (Mental Health Parity) and ORS 743A.190 (Children with Pervasive Developmental Disorders).

ORS 743A.168 (Mental Health Parity)
ORS 743A.168 states that:

“A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions.’

OAR 836-053-1404 defines "Mental or nervous conditions" as used in this statute to mean:

836-053-1404 Definitions; noncontracting providers; co-morbidity disorders
“(1) As used in ORS 743.556, this rule and OAR 836-053-1405:
(a) "Mental or nervous conditions" means:
(A) All disorders listed in the "Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition" except for:
(i) Diagnostic codes 317, 318.0, 318.1, 318.2, 319; Mental Retardation;
(ii) Diagnostic codes 315.00, 315.1, 315.2, 315.9; Learning Disorders;
(iii) Diagnostic codes 302.4, 302.81, 302.89, 302.2, 302.84, 302.82, 302.9; Paraphilias;
(iv) Diagnostic codes 302.85, 302.6, 302.9; Gender Identity Disorders in Adults. This exception does not extend to children and adolescents 18 years of age or younger; and
(v) Diagnostic codes V15.81 through V71.09; "V" codes. This exception does not extend to children 5 years of age or younger for diagnostic codes V61.20; Parent-Child Relational Problem through V61.21; Neglect, Physical Abuse, or Sexual Abuse of Child, and V62.82; Bereavement. “
While this definition of “Mental or nervous conditions” excludes some “developmental disabilities, developmental delays or learning disabilities”, such as mental retardation and learning disorders, other developmental disabilities, such as autism spectrum disorders (which are listed in DSM-IV-TR, with diagnostic code 299.0) are required for coverage.

Providence has used this contractual exclusion to deny coverage of all services for Autism, which it classifies as a “developmental disorder” despite the fact that autism (Diagnostic code 299.0) is clearly within the scope of this definition "Mental or nervous conditions", and that ORS 743A.168 clearly requires “coverage for expenses arising from treatment” for such conditions, including autism.

ORS 743A.190 (Children with pervasive developmental disorder)
ORS 743A.190 states that:

“A health benefit plan, as defined in ORS 743.730, must cover for a child enrolled in the plan who is under 18 years of age and who has been diagnosed with a pervasive developmental disorder all medical services, including rehabilitation services, that are medically necessary and are otherwise covered under the plan.”

It further defines “pervasive developmental disorder” to mean

“(3)(b) “Pervasive developmental disorder” means a neurological condition that includes Asperger’s syndrome, autism, developmental delay, developmental disability or mental retardation.”

ORS 743A.190 therefore requires coverage of “all medical services, including rehabilitation services, that are medically necessary and are otherwise covered under the plan” for “Asperger's syndrome, autism, developmental delay, developmental disability or mental retardation”.

Providence’s contractual exclusion for Mental Health “Services related to developmental disabilities, developmental delays or learning disabilities” is in direct violation of this statute.

Providence has used this contractual exclusion to deny coverage of all services related to treatment of Autism, despite a clear and specific mandate for coverage.

Clause: Exclusion of Speech, Physical, and Occupational Therapy

Text of Providence Contract:

7. EXCLUSIONS:
Exclusions that apply to Mental Health and Chemical Dependency Services: (page 45)
“Speech therapy, physical therapy and occupational therapy Services provided in connection with treatment of psychosocial speech delay, learning disorders, including mental retardation and motor skill disorders, and educational speech delay including delayed language development (except as provided in sections 5.4.3. and 5.9.3);”

Violations of Oregon Law:
This clause violates ORS 743A.190 (Children with Pervasive Developmental Disorders). See also the clause on “Limitations on Rehabilitative Services” below.
ORS 743A.190 (Children with pervasive developmental disorder)
ORS 743A.190 states that:

“A health benefit plan, as defined in ORS 743.730, must cover for a child enrolled in the plan who is under 18 years of age and who has been diagnosed with a pervasive developmental disorder all medical services, including rehabilitation services, that are medically necessary and are otherwise covered under the plan.”

It further defines “pervasive developmental disorder” and “Rehabilitation services” to mean:

“(3)(b) “Pervasive developmental disorder” means a neurological condition that includes Asperger’s syndrome, autism, developmental delay, developmental disability or mental retardation.
(3)(c) “Rehabilitation services” means physical therapy, occupational therapy or speech therapy services to restore or improve function.”

ORS 743A.190 therefore requires coverage of physical therapy, occupational therapy or speech therapy services for “Asperger’s syndrome, autism, developmental delay, developmental disability or mental retardation”.

Providence’s contractual exclusion for Mental Health “Speech therapy, physical therapy and occupational therapy Services provided in connection with treatment of psychosocial speech delay, learning disorders, including mental retardation and motor skill disorders, and educational speech delay including delayed language development” is in direct violation of this statute, at least with regards to mental retardation and any other forms of developmental disability or delay.

Clause: Exclusion of Institutions that Specialize in Treatment of Developmental Disabilities

Text of Providence Contract:

7. EXCLUSIONS:
    General Exclusions (page 43)
    “We do not cover Services and supplies which:
    Are provided in an institution that specializes in treatment of developmental disabilities;”

Violations of Oregon Law:
This clause violates ORS 743A.010 (Services provided by state hospital or state approved program), ORS 743A.168 (Mental Health Parity), and ORS 743A.190 (Children with Pervasive Developmental Disorders).

ORS 743A.010 (Services provided by state hospital or state approved program)
ORS 743A.010 states that:

“No policy of health insurance shall exclude from payment or reimbursement losses incurred by an insured for any covered service because the service was rendered at any hospital owned or operated by the State of Oregon or any state approved community mental health program or community developmental disabilities program.”

Paul Terdal August 6, 2012 Page 5 of 11
(503)984-2950 paul@AutismInsuranceOR.org
This contractual exclusion prohibits coverage of “services and supplies which are provided in an institution that specializes in treatment of developmental disabilities”, but makes no exception for a “state approved community mental health program or community developmental disabilities program” as required by law.

ORS 743A.168 (Mental Health Parity)
ORS 743A.168 states that:

“A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions.”

As noted above, OAR 836-053-1404 defines "Mental or nervous conditions" as used in this statute to include some but not all developmental disorders. Denying coverage of services and supplies because they are provided in an institution specializing in treatment of these covered conditions is on its’ face an illegal limitation that is more “more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions.”

ORS 743A.190 (Children with pervasive developmental disorder)
ORS 743A.190 states that:

“A health benefit plan, as defined in ORS 743.730, must cover for a child enrolled in the plan who is under 18 years of age and who has been diagnosed with a pervasive developmental disorder all medical services, including rehabilitation services, that are medically necessary and are otherwise covered under the plan.”

As noted above, this statute defines “Pervasive developmental disorder” to mean “a neurological condition that includes Asperger’s syndrome, autism, developmental delay, developmental disability or mental retardation.”

Denying coverage of services and supplies because they are provided in an institution specializing in treatment of these specifically covered conditions is a clear violation of this mandate to cover “all medical services ... that are medically necessary and are otherwise covered under the plan.”

Clause: Qualified Practitioners Limited to Licensed Professionals

Text of Providence Contract:

16. DEFINITIONS
Qualified Practitioner (page 94):
“Qualified Practitioner means a physician, Women’s Health Care Provider, nurse practitioner, nurse practitioner midwife, clinical social worker, physician assistant, psychologist, dentist, or other practitioner who is professionally licensed by the appropriate governmental agency to diagnose or treat an injury or illness and who provides Covered Services within the scope of that license.”
Violations of Oregon Law:
This clause violates ORS 743A.168 (Mental Health Parity), which specifies that “a provider is eligible for reimbursement” of mental health providers if the provider “is providing a covered benefit under the policy” or has been “approved by the Department of Human Services” — even if not professionally licensed.

ORS 743A.168 (Mental Health Parity)
In McHenry v PacificSource (Case 3:08-cv-00562-ST Document 118 Filed 09/28/10), Judge Stewart reviewed the requirements for mental health provider eligibility criteria under ORS 743A.168, and wrote:

“The requirements for insurance reimbursement eligibility under Oregon law are found in ORS 743A.010 et seq. ORS 743A.168 prescribes the requirements for provider eligibility criteria under group health policies and defines “provider” as follows:
(e) “Provider” means a person that has met the credentialing requirement of a group health insurer, is otherwise eligible to receive reimbursement for coverage under the policy and is:
(A) A health care facility;
(B) A residential program or facility;
(C) A day or partial hospitalization program;
(D) An outpatient service; or
(E) An individual behavioral health or medical professional authorized for reimbursement under Oregon law.
ORS 743A.168(1)(e) (emphasis added.)

A provider “is eligible for reimbursement” under Oregon law if:
(a) The provider is approved by the Department of Human Services;
(b) The provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities;
(c) The patient is staying overnight at the facility and is involved in a structured program at least eight hours per day, five days per week; or
(d) The provider is providing a covered benefit under the policy.
ORS 743A.168(5) (emphasis added.)”

In her analysis of this statutory language, Judge Stewart concluded that an unlicensed mental health provider was qualified for reimbursement for mental health services under ORS 743A.168 if that provider was approved by the Oregon Department of Human Services (ODHS).

Providence’s contractual requirement limiting “qualified practitioners” to those “professionally licensed by the appropriate governmental agency” thus violates ORS 743A.168, by improperly denying access to unlicensed providers who are approved by ODHS.

Clause: Limitations on Rehabilitative Services

Text of Providence Contract:
Hospital Services (Benefit Summary, page 2)
Rehabilitative care (30 days per calendar year)

Other Covered Services (Benefit Summary, page 3)

Outpatient rehabilitative services (30 visits per calendar year)

Violations of Oregon and Federal Law:
Assuming that the Providence contract were amended to cover treatment of autism as required by ORS 743A.168 and ORS 743A.190 (see clause “Exclusion of Speech, Physical, Occupational Therapy,” above), these clauses – including the limitation of 30 days per calendar year – would be consistent with the requirements of ORS 743A.190 (Children with Pervasive Developmental Disorders), which requires coverage of rehabilitative care “subject to other provisions of the health benefit plan that apply to covered services” including “Treatment limitations regarding the number of visits or the duration of treatment.”

However, for group plans, this limitation on the number of visits would violate ORS 743A.168 (Mental Health Parity) and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), with respect to treatment of autism.

ORS 743A.168 (Mental Health Parity)
ORS 743A.168 states that:

“A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions.”

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
MHPAEA (H. R. 1424, Subtitle B, Section 512 (a) (1) (A)) states:

“(A) IN GENERAL.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that—
(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and
(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.”

Discussion:
Both the Oregon and Federal mental health parity laws impose similar requirements that coverage of treatment for mental health conditions – including autism – shall be subject to treatment limitations no more restrictive “the predominant treatment limitations applied to substantially all medical and surgical benefits” (to use the construction of the Federal MHPAEA statute).
This provision violates this requirement by imposing a limitation on the number of visits (up to 30 visits) for rehabilitative services for treatment of autism, a protected mental health condition, that is not “applied to substantially all medical and surgical benefits covered by the plan”

In Z.D. v Group Health Cooperative, in U.S. District Court for the Western District of Washington (Case No. C11-1119RSL. June 1, 2012), Judge Robert S. Lasnik determined that Group Health Cooperative was in violation of the State of Washington’s Mental Health Parity for terminating coverage of speech therapy as a treatment for autism at age 7, writing:

“The Court ORDERS Defendants to cease denying coverage for medically necessary neurodevelopmental therapy to treat insureds with DSM-IV-TR mental health conditions simply because the insured is over six years old. Moreover, the Court ORDERS Defendants to cease their application of any treatment limitations that are not generally “imposed on coverage for medical and surgical services.” RCW 48.46.291(2)(c)(i). The Court will not look kindly on failures to immediately implement its directive.”

Judge Lasnik explained that while Washington’s “Neurodevelopmental Therapies Mandate” (RCW 48.44.450) mandates “coverage for neurodevelopmental therapies for covered individuals age six and under”, that this simply “established a coverage floor, not a ceiling” and that the Mental Health Parity Act merely imposed an additional, distinct requirement that mental health coverage “be delivered under the same terms and conditions as medical and surgical services.” The analogy to Oregon’s “Children with Pervasive Developmental Disorders” mandate (ORS 743A.190) – which is limited in scope to “a child enrolled in the plan who is under 18 years of age” – is clear.

While this particular case focused on an illegal age limit, the same argument applies to visit limitations on coverage for mental health conditions (including autism) that are more restrictive than those imposed on “substantially all medical and surgical benefits covered by the plan”:

“Defendants argue that they are in compliance with RCW 48.46.291(2)(c) because Group Health applies the same treatment limitations to mental health therapy services that it applies to all therapies services. Opp. (Dkt. # 53) at 16 (“Group Health imposes a treatment limit (age seven) on a limited set of therapies (speech therapy, physical therapy and occupational therapy) that treat medical and mental conditions alike.”). In actuality, however, Group Health does not apply an age-based treatment limitation across the board to all therapies related to medical and surgical services”

In other words, as required by MHPAEA, the comparison standard for treatment limitations on rehabilitative therapies for mental health conditions is to “treatment limitation across the board to all therapies related to medical and surgical services” – NOT to treatment limitations imposed on similar rehabilitative therapies for medical and surgical conditions.

If the plan limited “substantially all medical and surgical benefits” to 60 visits per year, then it would be permitted to limit rehabilitative therapies for mental health conditions such as autism to 60 visits per year. Since the plan does not impose such visit limits on “substantially all medical and surgical benefits”, it cannot impose visit limits on rehabilitative services (and, under PPACA, habilitative services) as a
treatment for mental health conditions including autism – even if it does impose visit limits on similar rehabilitative services for medical and surgical conditions.

**Clause: External Review**

**Text of Providence Contract:**

9.2.4. **External Review** *(page 57):*

“By electing to submit your appeal to an IRO, you are also agreeing to be bound by and to comply with the IRO decision regarding your appeal in lieu of appealing to a state or federal court.”

**Violations of Oregon Law:**

Oregon law (ORS 743.857, 743.859, 743.863, 743.864) establishes a consumer right to appeal to external review, and a civil penalty for insurers who fail to comply with an IRO decision. Unlike some other states, there is no requirement that consumers (enrollees) waive their right to sue if they choose external review by an IRO.

**ORS 743.859 (Notice to enrollee of right to sue if insurer does not follow decision of independent review organization)**

ORS 743.859 states that:

An insurer of a health benefit plan shall include in the plan the following statements, in boldfaced type or otherwise emphasized:

(1) A statement of the right of enrollees to apply for external review by an independent review organization; and

(2) A statement that if the insurer does not follow a decision of an independent review organization, the enrollee has the right to sue the insurer.

Providence has violated this statute by including an additional statement that is not supported by Oregon law – that the enrollee is “also agreeing to be bound by and to comply with the IRO decision regarding your appeal in lieu of appealing to a state or federal court.”

An enrollee does have a right under Oregon law to appeal to a state or federal court, even if they first choose external review. *(Note that under ORS 743.863(2), “A decision of an independent review organization is admissible in any legal proceeding involving the insurer or the enrollee and involving the disputed issues subject to external review.”)*

Providence may not restrict the enrollee’s statutory right to external review by adding its’ own conditions.

Paul Terdal
August 6, 2012
(503)984-2950 paul@AutismInsuranceOR.org
Conclusion

Providence has actively used these illegal clauses to deny benefits mandated under Oregon law. As Providence wrote to a parent requesting coverage of Applied Behavior Analysis (ABA) as a treatment for her son’s autism, in a July 24, 2012 denial of a first level appeal:

“Under the language of the Providence Open Option group member handbook, services ‘related to developmental disabilities, developmental delays, or learning disabilities’ as specifically excluded from coverage under this plan. ... There is no question but that autism spectrum disorder is a ‘developmental disability’ or involves ‘developmental delay,’ and Providence as the plan administrator here has so interpreted it, in this case as it has in other cases seeking ABA services for autism spectrum disorder. Because ABA services are related to autism spectrum disorder, they are therefore not benefits covered by the plan.”

Ironically, Providence closed this letter with this statement:

“Your contention that Providence is not ‘comply[ing] with Oregon law’ is untrue, and not appreciated.”

Providence’s violation of Oregon laws requiring coverage of developmental disability, development delay, and autism spectrum disorder (ORS 743A.190 and ORS 743A.168) could not be more flagrant. It is regrettable that Providence did not take the opportunity afforded by this parent’s first level appeal to bring itself into compliance.
July 24, 2012

PORTLAND, OR

Re: [ Może restored here ]
ID # [ Maybe restored here ]

Dear Ms. [ Name restored here ]:

Thank you for contacting Providence Health Plans (PHP) with your concerns regarding the denial for your son's, [ Name restored here ], applied behavioral analysis services. This letter responds to your initial appeal dated May 27, 2012, which we received June 25, 2012, in the matter referenced above. We have determined that we must uphold the denial on appeal, for the reasons noted below.

The Basis for the Denial Decision

PBH’s denial letter to you based PBH’s denial on the fact that under Providence’s Medical Policy and Criteria for Autism Spectrum Disorders / Pervasive Developmental Disorders Assessment and Treatment classifies Applied Behavior Analysis (“ABA”) services as experimental and investigational. We have decided neither to overturn nor to affirm the decision on that basis, reserving Providence’s rights under that policy but focusing on a different issue.

Under the language of the Providence Open Option group member handbook, services “related to developmental disabilities, developmental delays or learning disabilities” are specifically excluded from coverage under this plan. (See Group Member Handbook, at 43). There is no question but that autism spectrum disorder is a “developmental disability” or involves “developmental delay,” and Providence as the plan administrator here has so interpreted it, in this case as it has in other cases seeking ABA services for autism spectrum disorder. Because ABA services are related to autism spectrum disorder, they are therefore not benefits covered by the plan.

Your Arguments

Most of your argument addresses the question of “experimental/investigational,” on which we have different perspectives but which is not the basis of this first level appeal decision. The decision of an IRO in another case, to which you make reference, is not binding except with respect to that case, and has no relevance to whether the exclusion quoted above applies to ABA services.

You contend that ORS 746.230, Oregon’s Unfair Claim Settlement Practices Act, has relevance to this case. Providence is not and has not misrepresented any facts or its policy provisions, and has not in this case or any other to our knowledge failed to attempt to settle when “liability has become reasonably clear.” The vote of Dr. Pass at the Commission on Autism Spectrum Disorder has no bearing on the meaning of the language applicable to this case. Your contention that Providence is not “comply[ing] with Oregon law” is untrue, and not appreciated.
If you do not agree with this decision, you have the right to a 2nd level appeal. Please see the enclosed Grievance and Appeals Rights for additional information regarding the process.

If you have any questions, please call your Customer Service Team at (503) 574-7500 or 1-800-878-4445, or the TDD/TTY number for the hearing impaired at (503) 574-8702 or 1-888-244-6642.

Sincerely,

[Signature]

Jennifer S.
Appeals and Grievances Department
Providence Health Plan

Enclosures
GRIEVANCE AND APPEAL RIGHTS FOR MEMBERS OF OREGON-BASED COMMERCIAL GROUPS

Your Grievance and Appeal Rights: If you disagree with our decision about your medical bills or health care services you have the right to two levels of internal review. You may request review if you believe that we have not paid a bill correctly, will not approve care you believe should be covered, or are stopping care you believe you still need. You may also file a quality of care or general complaint with us. Please include as much information as possible including the date of the incident, the names of individuals involved, and the specific circumstances.

In filing a grievance or appeal:

- You can submit written comments, documents, records and other information relating to your grievance or appeal and we will consider that information in our review process.
- You can, upon request and free of charge, have reasonable access to and copies of the documents and records held by us that relate to your grievance or appeal.

Filing a grievance or appeal does not affect your right to receive benefits for Covered Services as otherwise provided under this Plan. To the extent possible, complaints filed by telephone will be resolved at the point of service by a Customer Service representative. All grievances and appeals (except those involving prior authorizations, as noted below) will be acknowledged within seven days of receipt by us and resolved within 30 days, or sooner depending on the clinical urgency. We may request an additional 15 days to resolve the issue if we provide you with a notice of delay, including the reason for the delay, before the 30 day period has elapsed.

Urgent Medical Conditions: If you believe your health would be seriously harmed by waiting for our decision on your grievance or appeal of a denied prior authorization request, you may request an expedited review by calling a Customer Service representative at 503-574-7500 or 1-800-878-4445 outside of the Portland area. If your appeal is urgent and qualifies for external review, you may request to have both your internal and external appeal expedited at the same time. We will let you know by phone and letter if your case qualifies for an expedited review. If it does, we will notify you of our decision within 72 hours of receiving your request.

Grievances and Appeals Involving Prior Authorizations (Non-Urgent): If your grievance or appeal involves a prior authorization request for a non-urgent medical condition, we will notify you of our decision, (a) within 15 days of receiving your request for a first level grievance or appeal or, (b) within 15 days of receiving your request for a second level appeal.

Grievances and Appeals Involving Concurrent Care Decisions: If we have approved an ongoing course of treatment for you and determine through our medical management procedures to reduce or terminate that course of treatment, we will provide advance notice to you of that decision. You may request reconsideration of our decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. We will then notify you of our reconsideration decision within 24 hours of receiving your request.

First Level Grievance or Appeal: You must file your first level grievance or appeal within 180 days of the date on our notice of the initial determination, or that initial determination will become final. Please advise us of any additional information that you want considered in the review process. If you are seeing a non-participating provider, you should contact that provider’s office and arrange for the necessary records to be forwarded to us for the review process. Your grievance or appeal will be reviewed by Providence Health Plan staff not involved in the initial determination. You may present your case in writing. Once a final determination is made you will be sent a written explanation of the decision.
Second Level Appeal: If you are not satisfied with our decision on the first level grievance or appeal, you may request a second level appeal and our Grievance Committee will review your case. The Grievance Committee is made up of individuals not involved in the initial grievance or appeal, and consists of Providence Health Plan staff and one or more community representatives. You must submit your written request for the Grievance Committee review within 60 days of the date on the first level grievance or appeal decision notice, or that first level decision will become final. You may present your case to the Grievance Committee in writing, by telephone conference call, or in person at our Beaverton, Oregon location. The Grievance Committee will review the documentation presented by you and send a written explanation of its decision.

External Review: If you are not satisfied with the decision of the Grievance Committee and your appeal involves a denial of services because they are not medically necessary, not an active course of treatment for purposes of continuity of care, because they are experimental/investigational, or whether a course of treatment is delivered in an appropriate setting at an appropriate level of care, you may request an external review by an Independent Review Organization (IRO). Your request must be made in writing within 180 days of receipt of the Grievance Committee’s final review decision, or that internal decision will become final. If you agree, we may waive the requirement that you exhaust the internal review process before beginning the External Review process. When the external review process is begun, an IRO will be assigned to the case by the Oregon Insurance Division and we will forward complete documentation regarding the case to the IRO. The IRO is entirely independent of Providence Health Plan and performs its review under a contract with the Oregon Insurance Division. The IRO will notify you and us of its decision. We agree to be bound by and to comply with the IRO decision when the decision involves, (a) medically necessary treatment, (b) experimental/investigational treatment, (c) an active course of treatment for purposes of continuity of care, or (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care. All costs for the handling of external review cases are paid by us and we administer these provisions in accordance with the insurance laws and regulations of the State of Oregon. By electing to submit your appeal to an IRO, you are also agreeing to be bound by and to comply with the IRO decision regarding your appeal in lieu of appealing to a state or federal court. If we do not comply with the IRO decision, you have the right to sue us under applicable Oregon law.

How to Submit Grievances or Appeals: To submit your grievance or appeal, or to request our annual report on grievances and internal appeals, you may contact a Customer Service representative at 503-574-7500 or 1-800-878-4445. If you are hearing impaired and use a Teletype (TTY) Device, please call our TTY line at 503-574-8702 or 1-888-244-6642. Written grievances or appeals should be sent to:

Providence Health Plan
Appeals and Grievance Department
PO Box 4327
Portland, Oregon 97208-4327

You may fax your grievance or appeal to 503-574-8757 or 1-800-396-4778, or you may hand deliver it (if mailing, use only the post office box address listed above) to the following address:

Providence Health Plan
3601 SW Murray Blvd., Suite 10
Beaverton, Oregon 97005

Assistance Outside of Providence Health Plan: You may, at any time during the grievance and appeal process, seek assistance from the Oregon Insurance Division with your concerns regarding our decisions and benefits. You may contact the Oregon Insurance Division at the following address:

Oregon Insurance Division, Consumer Protection Unit
PO Box 14480, Salem, OR 97301-3883
503-947-7984 (phone) or 1-888-877-4894 (toll-free)
503-378-4351 (fax)
cp.ins@state.or.us (e-mail)
http://www.cbs.state.or.us/ins/consumer/consumer/html (internet)
# TABLE OF CONTENTS

1. **INTRODUCTION** .................................................................................................................................. 1

2. **WELCOME TO PROVIDENCE HEALTH PLAN** .................................................................................. 2
   - 2.1 PERSONAL OPTION PLAN ........................................................................................................... 2
   - 2.2 MEMBER HANDBOOK .................................................................................................................. 2
   - 2.3 CUSTOMER SERVICE ................................................................................................................ 3
   - 2.4 REGISTERING FOR A MyPROVIDENCE ACCOUNT .............................................................. 3
   - 2.5 YOUR MEMBER ID CARD ........................................................................................................... 3
   - 2.6 PROVIDENCE RN ........................................................................................................................ 4

3. **ELIGIBILITY AND ENROLLMENT** ................................................................................................. 5
   - 3.1 EMPLOYEE ELIGIBILITY AND ENROLLMENT ........................................................................... 5
     - 3.1.1 Employee Eligibility Date .......................................................................................................... 5
     - 3.1.2 Employee Effective Date ......................................................................................................... 5
     - 3.1.3 Employee Enrollment ............................................................................................................. 5
   - 3.2 DEPENDENT ELIGIBILITY AND ENROLLMENT ....................................................................... 5
     - 3.2.1 Eligibility Date ......................................................................................................................... 5
     - 3.2.2 Additional Requirements for Eligible Family Dependent Coverage ...................................... 6
     - 3.2.3 Eligible Family Dependent Enrollment .................................................................................... 6
     - 3.2.4 Newborn Eligibility and Enrollment ......................................................................................... 6
     - 3.2.5 Open Enrollment Period ......................................................................................................... 6
     - 3.2.6 Changes in Eligibility ............................................................................................................... 6
     - 3.2.7 Members No Longer Eligible for Coverage ........................................................................... 7
   - 3.3 OUT-OF-AREA DEPENDENTS ................................................................................................... 7
     - 3.3.1 Change of Status ...................................................................................................................... 7
   - 3.4 SPECIAL ENROLLMENT PERIODS .............................................................................................. 7
     - 3.4.1 Loss of Other Coverage .......................................................................................................... 8
     - 3.4.2 New Dependents ...................................................................................................................... 8
     - 3.4.3 Court Orders ............................................................................................................................ 9
     - 3.4.4 Premium Assistance ................................................................................................................. 9
   - 3.5 MEMBERS AFFECTED BY A REPLACEMENT OF GROUP COVERAGE .................................... 9
   - 3.6 LEAVE OF ABSENCE AND LAYOFFS ....................................................................................... 10

4. **HOW TO USE YOUR PLAN** ......................................................................................................... 11
   - 4.1 PARTICIPATING PROVIDERS ....................................................................................................... 11
     - 4.1.1 Nationwide Network of Participating Providers ....................................................................... 11
     - 4.1.2 Choosing a Participating Provider ............................................................................................ 11
     - 4.1.3 Indian Health Services Providers ............................................................................................. 11
   - 4.2 THE ROLE OF A PERSONAL PHYSICIAN/PROVIDER .............................................................. 12
     - 4.2.1 Personal Physicians/Providers .................................................................................................. 12
     - 4.2.2 Established Patients with Personal Physicians/Providers ...................................................... 12
     - 4.2.3 Selecting a New Personal Physician/Provider ......................................................................... 12
     - 4.2.4 Changing Your Personal Physician/Provider ........................................................................... 13
     - 4.2.5 Office Visits ............................................................................................................................. 13

PGC-OR 0811 EPO PERSONAL HBK
Providence Health Plan
5. COVERED SERVICES ................................................................. 23
  5.1 PROVIDER SERVICES ............................................................... 23
      5.1.1 Office Visits, Inpatient and Outpatient Hospital Visits, and Home Visits ......... 23
      5.1.2 E-visits ........................................................................... 24
      5.1.3 Telemedical Services ....................................................... 24
      5.1.4 Administration of Anesthesia and Surgical Procedures .............................. 25
  5.2 PREVENTIVE SERVICES ......................................................... 25
      5.2.1 Physical Examinations and Well-Baby Care ............................................. 25
      5.2.2 Immunizations and Vaccinations ......................................................... 26
      5.2.3 Prostate Cancer Screening Exams ....................................................... 26
      5.2.4 Colorectal Cancer Screening Exams ...................................................... 26
      5.2.5 Preventive Services for Members with Diabetes ...................................... 26
  5.3 WOMEN’S HEALTH CARE SERVICES ..................................... 26
      5.3.1 Gynecological Examinations ......................................................... 27
      5.3.2 Mammograms ........................................................................ 27
      5.3.3 Family Planning Services ............................................................ 27
      5.3.4 Maternity Services ....................................................................... 27
  5.4 HOSPITAL AND SKILLED NURSING FACILITY SERVICES ......... 28
      5.4.1 Hospital Services ....................................................................... 28
      5.4.2 Skilled Nursing Facility ............................................................... 29
      5.4.3 Inpatient Rehabilitation Services .................................................... 29
      5.4.4 Observation Care ........................................................................... 29
  5.5 EMERGENCY CARE SERVICES .............................................. 30
      5.5.1 Emergency Care ........................................................................ 30
      5.5.2 Emergency Medical Transportation ................................................. 31
      5.5.3 Emergency Eye Care Services ....................................................... 31
      5.5.4 Emergency Detoxification Services .................................................. 31
5.6 URGENT/IMMEDIATE CARE SERVICES ................................................................. 31
5.7 MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES ................... 32
5.7.1 Mental Health Services .................................................................................. 32
5.7.2 Chemical Dependency Services ...................................................................... 32
5.8 MEDICAL SUPPLIES, MEDICAL APPLIANCES, PROSTHETIC AND ORTHOTIC
DEVICES, DURABLE MEDICAL EQUIPMENT (DME) AND HEARING AIDS .......... 32
5.8.1 Medical Supplies (Including Diabetes Supplies) .............................................. 33
5.8.2 Medical Appliances ........................................................................................ 33
5.8.3 Prosthetic and Orthotic Devices ..................................................................... 33
5.8.4 Durable Medical Equipment (DME) ............................................................... 34
5.8.5 Hearing Aids .................................................................................................... 34
5.9 OTHER COVERED SERVICES ............................................................................ 34
5.9.1 Outpatient Hospital Services, Chemotherapy and Radiation Therapy ............ 34
5.9.2 Self-Administered Chemotherapy .................................................................. 34
5.9.3 Short-Term Outpatient Rehabilitation ............................................................ 34
5.9.4 Allergy Shots, Allergy Serums and Injectable Medications .............................. 35
5.9.5 Podiatry/Foot Services .................................................................................... 35
5.9.6 Reconstructive Surgery .................................................................................. 35
5.9.7 Reconstructive Breast Surgery ...................................................................... 35
5.9.8 Diagnostic Pathology, Radiology Tests and Diagnostic Procedures ............... 35
5.9.9 Diabetes Self-Management Education Program ............................................. 36
5.9.10 Inborn Errors of Metabolism ........................................................................ 36
5.9.11 Nutritional Counseling .................................................................................. 36
5.9.12 Home Health Care ....................................................................................... 36
5.9.13 Hospice Care .................................................................................................. 37
5.10 BASIC PLAN ADDITIONAL COVERED SERVICES ........................................ 38
5.10.1 Vision and Hearing Screening Exams for Members Through Age 17 ............... 38
5.10.2 Focal Surgery for Epilepsy .......................................................................... 38
5.10.3 Children’s Dental Services .......................................................................... 38
5.10.4 Children’s Hearing Aids .............................................................................. 38
6. LIMITED COVERED SERVICES ........................................................................... 39
6.1 HUMAN ORGAN/TISSUE TRANSPLANTS ...................................................... 39
6.1.1 Covered Services ......................................................................................... 39
6.1.2 Benefits for Transplant Facility Services Provided to the Organ Recipient ....... 40
6.1.3 Benefits for Outpatient Medications ............................................................ 40
6.1.4 Benefits for Physician/Provider Services Provided to the Organ Recipient .... 40
6.1.5 Prior Authorization ...................................................................................... 40
6.1.6 Exclusion Period ......................................................................................... 40
6.1.7 Exclusions .................................................................................................. 41
6.2 RESTORATION OF HEAD/FACIAL STRUCTURES; LIMITED DENTAL SERVICES .. 41
6.2.1 Temporomandibular Joint (TMJ) Services ...................................................... 42
6.2.2 Outpatient Hospitalization and Anesthesia for Dental Services .................... 42
6.3 TOBACCO USE CESSATION SERVICES ..................................................... 42
7. EXCLUSIONS ......................................................................................................... 43
8. CLAIMS ADMINISTRATION ................................................................................. 47
11.2.7 COBRA Premiums ................................................................. 63
11.2.8 Length of COBRA Continuation Coverage ................................................................. 64
   18-Month Continuation Period ................................................................. 64
   29-Month Continuation Period ................................................................. 64
   36-Month Continuation Period ................................................................. 64
11.2.9 Extension of Continuation Period .............................................................................. 64
11.2.10 Other Information ......................................................................................... 64
11.3 CONTINUATION OF BENEFITS DURING LABOR STRIKE ........................................... 65
11.4 CONTINUATION OF BENEFITS AFTER INJURY OR ILLNESS COVERED BY WORKERS’ COMPENSATION INSURANCE ......................................................... 65
11.5 COVERAGE EXTENSIONS ...................................................................................... 65

12. INDIVIDUAL PORTABILITY PLANS ........................................................................ 66
   12.1 ELIGIBILITY ...................................................................................... 66
   12.2 PORTABILITY PLANS ........................................................................... 66
   12.3 EFFECTIVE DATE AND PREMIUM .................................................... 67

13. MEMBER RIGHTS AND RESPONSIBILITIES ................................................................ 68
   13.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES ....... 68
   13.2 ERISA INFORMATION FOR MEMBERS (PARTICIPANTS) ......................... 69
   13.3 NON-ERISA INFORMATION FOR MEMBERS (PARTICIPANTS) ................. 71

14. GENERAL PROVISIONS .................................................................................. 72
   14.1 AMENDMENT OF THE GROUP CONTRACT .............................................. 72
   14.2 AVAILABILITY OF CONTRACT .................................................................. 72
   14.3 BINDING EFFECT ..................................................................................... 72
   14.4 CIRCUMSTANCES BEYOND THE CONTROL OF PROVIDENCE HEALTH PLAN .... 72
   14.5 CHOICE OF STATE LAW ........................................................................ 72
   14.6 DUPLICATING PROVISIONS ..................................................................... 72
   14.7 FAILURE TO PROVIDE INFORMATION OR PROVIDING INCORRECT OR INCOMPLETE INFORMATION .............................................................. 72
   14.8 HOLD HARMLESS ................................................................................... 73
   14.9 INTEGRATION ......................................................................................... 73
   14.10 LEGAL ACTION ....................................................................................... 73
   14.11 NON-TRANSFERABILITY OF BENEFITS .................................................. 73
   14.12 NONWAIVER ......................................................................................... 73
   14.13 NO RECOUSE FOR ACTS OF PROVIDERS ............................................. 73
   14.14 NOTICE ................................................................................................. 74
   14.15 PHYSICAL EXAMINATION AND AUTOPSY ........................................... 74
   14.16 PROFESSIONAL REVIEW AND RIGHT TO EXAMINE RECORDS .......... 74
   14.17 PRORATION OF BENEFITS .................................................................... 74
   14.18 SEVERABILITY ....................................................................................... 74
   14.19 SUGGESTIONS ....................................................................................... 74
   14.20 WORKERS’ COMPENSATION INSURANCE ............................................. 74

15. SUPPLEMENTAL BENEFITS ............................................................................... 75
   15.1 PRESCRIPTION DRUG SUPPLEMENTAL BENEFIT .................................. 75
       15.1.1 Using Your Prescription Drug Benefit .................................................. 75
       15.1.2 Use of Non-Participating Pharmacies .............................................. 76
15.1.3 Prescription Drug Formulary ................................................................. 76
15.1.4 Generic, Brand-Name and Value-Based Prescription Drugs ................ 77
15.1.5 Prescription Drug Quantity ................................................................. 77
15.1.6 Participating Mail-Order and Preferred Retail Pharmacies .................. 77
15.1.7 Prescription Drug Out-of-Pocket Maximum ........................................ 78
15.1.8 Prescription Drug Limitations .............................................................. 78
15.1.9 Prescription Drug Exclusions ............................................................... 79
15.1.10 Prescription Drug Disclaimer ............................................................. 80
15.2 ALTERNATIVE CARE SUPPLEMENTAL BENEFIT ............................... 80
  15.2.1 Alternative Care Providers ................................................................. 80
  15.2.2 Acupuncture Care Services ............................................................... 81
  15.2.3 Chiropractic Care Services ............................................................... 81
  15.2.4 Naturopathic Care Services .............................................................. 82
  15.2.5 General Exclusions to Alternative Care Services .............................. 82
15.3 CHIROPRACTIC CARE SUPPLEMENTAL BENEFIT .............................. 83
  15.3.1 Chiropractic Care Providers ............................................................... 83
  15.3.2 Chiropractic Care Services ............................................................... 84
15.4 VISION CARE SUPPLEMENTAL BENEFIT .......................................... 84
15.5 ELECTIVE STERILIZATION SUPPLEMENTAL BENEFIT ..................... 85
16. DEFINITIONS ............................................................................................. 86
1. INTRODUCTION

Thank you for choosing Providence Health Plan. We look forward to meeting your health care needs. The following is a brief outline of several key aspects of this Personal Option Plan.

- Some capitalized terms have special meanings. Please see section 16, Definitions.
- In this handbook, Providence Health Plan is referred to as “we,” “us” or “our.” Members enrolled under this Personal Option Plan are referred to as “you” or “your.”
- Coverage under this Personal Option Plan is provided through:
  - Our network of Participating Providers located in our Service Area; and
  - Our national network of Participating Providers.
- Covered Services must be obtained from Participating Providers, with the following exceptions:
  - Emergency Services and Urgent/Immediate Care Services, as specified in sections 5.5, and 5.6;
  - Covered Services received by an enrolled Out-of-Area Dependent, as specified in section 4.5; and
  - Covered Services delivered by a Non-Participating Provider when those Services have been approved in advance through the Prior Authorization procedures specified in section 4.3 and 4.6.
- All Members are encouraged to choose a Personal Physician/Provider who will provide preventive and primary care Services and coordinate other care in a convenient and cost-effective manner.
- A printable directory of Participating Providers in our Service Area is available at www.providence.org/healthplans. Members without Internet access or who would like a hard copy of our Provider Directory may contact Customer Service for assistance. NOTE: Printed provider directories are updated only once each year and, therefore, may not contain the most up-to-date information.
- Certain Covered Services require an approved Prior Authorization, as specified in section 4.6.
- For Members of Small Group Plans who are age 19 and older, most Covered Services are subject to a Pre-existing Conditions Exclusion, as stated in section 4.11.
- Human organ/tissue transplants are subject to an Exclusion Period, as stated in section 6.1.
- Coverage under this Personal Option Plan is available 24 hours a day, seven days a week and during periods of domestic or foreign travel.
- All Covered Services are subject to the provisions, limitations and exclusions that are specified in this Personal Option Plan. You should read the provisions, limitation and exclusions before seeking Covered Services, because not all health care services are covered by this Personal Option Plan.
- The Group Contract for this Personal Option Plan consists of this Member Handbook plus the Employer/Group Agreement, Rate Summary, Benefit Summaries, and any Endorsements and amendments that accompany either the Employer/Group Agreement or this document. In the event of any conflict between these documents, they are to be interpreted in the following order of priority: (1) Endorsements and amendments, (2) Employer/Group Agreement, (3) Member Handbook, (4) Benefit Summary, and (5) Rate Summary.
2. WELCOME TO PROVIDENCE HEALTH PLAN

Providence Health Plan is an exclusive provider organization (EPO) plan offered by Providence Health & Services. The organization consists of a network of hospitals, clinics, urgent care centers, physicians, other health care providers and health plans. Our goal is to help improve the health status of individuals in the communities in which we serve.

2.1 PERSONAL OPTION PLAN

Your Personal Option Plan allows you to receive Covered Services from Participating Providers.

It is your responsibility to verify whether or not a physician/provider, hospital or other facility is participating with us, and whether or not the health care is a Covered Service even if you have been directed or referred for care by a Participating Provider.

If you are unsure about a physician/provider’s, hospital’s or other facility’s participation with Providence Health Plan, visit our Provider Directory, available online for Personal Option Plan Members at www.providence.org/healthplans, before you make an appointment. You also can call Customer Service to get information about a provider’s participation with Providence Health Plan and your Covered Services.

Whenever you visit a Participating Provider:

- Bring your Providence Health Plan Member ID Card with you.
- Be prepared to make a Copayment at the time of visit if the office visit is subject to a Copayment.
- If your office visit is subject to a Coinsurance (a percentage of the amount billed for Services), you will most likely not be able to pay for what you owe at the time of your visit. Your provider’s office will send you a bill for what you owe later. Some providers, however, may ask you to pay an estimate of what you may owe at the time you receive services, and bill or credit you for the balance later.

2.2 MEMBER HANDBOOK

This Member Handbook contains important information about the health plan coverage we offer to employees of Oregon Employers. It is important to read this Member Handbook carefully as it explains your Providence Health Plan benefits and Member responsibilities. If you do not understand a term that is used, you may find it in Definitions, section 16. If you need additional help understanding anything in this Member Handbook, please call Customer Service at 503-574-7500 or 800-878-4445. See section 2.3 for additional information on how to reach Customer Service.

This Member Handbook is not complete without your:

- **Personal Option Benefit Summary** and any other Supplemental Benefit Summary documents. These materials are available at www.providence.org/healthplans when you register for a myProvidence account as explained in section 2.4. Benefit Summaries detail your Copayments and Coinsurance for Covered Services and also provide important information for any Supplemental Benefits you have (like prescription drugs or vision).
- **Provider Directory**, which lists Participating Providers, available online at www.providence.org/healthplans. If you do not have Internet access, please call Customer Service or check with your Employer’s human resource department to obtain a hard copy of the directory.

If you need more detailed information for a specific problem or situation, contact your Employer or Customer Service.
2.3 CUSTOMER SERVICE

We want you to understand how to use your Providence Health Plan benefits and to be satisfied with your health plan coverage. Customer Service is available to assist you in understanding your benefits and resolving any problems you may have, including:

- Specific benefit or claim questions.
- Address and name changes.
- Questions or concerns about adding or dropping a dependent.
- Enrollment issues.
- Questions or concerns about your health care or service.

Contacting Providence Customer Service

Customer Service representatives are available by phone from 8 a.m. to 5 p.m., Monday through Friday, (excluding holidays). Please have your Member ID Card available when you call:

- Members in the Portland-metro area, please call 503-574-7500.
- Members in all other areas, please call toll-free: 800-878-4445.
- Members with hearing impairment, please call the TTY line: 503-574-8702 or toll-free 888-244-6642.

You may access claims and benefit information 24 hours a day, seven days a week through our automated voice-recognition phone as well as online through your myProvidence account.

2.4 REGISTERING FOR A MyPROVIDENCE ACCOUNT

Members can create a myProvidence account online. A myProvidence account enables you to view your personal health plan information (including your Member Handbook and Benefit Summary), view claims history and benefit payment information, order a replacement Member ID Card, and access other health and wellness tools and services.

2.5 YOUR MEMBER ID CARD

Each Member of Providence Health Plan receives a Member ID Card. Your Member ID Card lists information about your health plan coverage, including:

- Your Member number and group number
- Your particular health plan
- Important phone numbers

The Member ID Card is issued by Providence Health Plan for Member identification purposes only. It does not confer any right to Services or other benefits under this Member Handbook.

Supplemental Benefits are any benefits purchased by your Employer in addition to your medical health care coverage (e.g., prescription drug, alternative care, chiropractic care, vision and elective sterilization). Member ID Cards do not list all of your Supplemental Benefits. If your Plan includes coverage for Supplemental Benefits, your Member materials will include a separate Benefit Summary for each Supplemental Benefit. See section 15 for additional information.

When scheduling an appointment or receiving health services, identify yourself as a Providence Health Plan Member, present your Member ID Card and pay your Copayment or Coinsurance.
Please keep your Member ID Card with you and use it when you:

- Visit your health care provider or facility.
- Call for Mental Health/Chemical Dependency Customer Service.
- Call or correspond with Customer Service.
- Call Providence RN medical advice line.
- Visit your pharmacy for prescriptions.
- Receive Immediate, Urgent or Emergency Care Services.

2.6 PROVIDENCE RN

Providence RN — 503-574-6520; toll-free 800-700-0481; TTY 800-735-2900

Providence RN is a free medical advice line for Providence Health Plan Members. Available 24 hours a day, seven days a week, a registered nurse can answer your health-related questions.

Members often call Providence RN when they have sick children, or when they have questions about how to treat flus, colds or backaches. After a brief recorded message, a registered nurse will come on line to assist you.

Please have your Member ID Card available when you call.

Important note for residents of California: In accordance with California state law, the services of Providence RN are not available to residents of California.
3. ELIGIBILITY AND ENROLLMENT

This section outlines who is eligible for coverage, and how and when to enroll yourself and your Eligible Family Dependents. No benefits shall be available to anyone not enrolled on your Personal Option Plan. You and your Employer must provide us with evidence of eligibility as requested.

3.1 EMPLOYEE ELIGIBILITY AND ENROLLMENT

Employers decide when their employees are eligible for health care coverage. Your Employer may require you to work a certain length of time, called an Eligibility Waiting Period, before you qualify to enroll in the Plan. If an Eligibility Waiting Period exists, it will be outlined in the Employer/Group Agreement on file with your Employer.

3.1.1 Employee Eligibility Date

An employee is eligible for coverage when:
1. The eligibility requirements stated in the Employer/Group Agreement are satisfied;
2. The employee is an Eligible Employee; and
3. The employee meets the Service Area requirement stated in the Employer/Group Agreement or the out-of-area Subscriber requirements of this Personal Option Plan.

3.1.2 Employee Effective Date

The Effective Date of Coverage is usually the first day of the month following the completion of any Eligibility Waiting Period. Your Employer determines when coverage will begin.

3.1.3 Employee Enrollment

The Eligible Employee must enroll on forms provided and/or accepted by us. To obtain coverage, an Eligible Employee must enroll within the time period specified in the Employer/Group Agreement after becoming eligible. Generally, an Employee has 30 days to enroll.

If you decline coverage or fail to enroll when you first become eligible, the next earliest time you may enroll is the next occurring Open Enrollment Period.

In certain situations, you and/or your Eligible Family Dependents may qualify to enroll during a special enrollment period. See section 3.4 for additional information.

3.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

3.2.1 Eligibility Date

Most Plans allow Subscribers to enroll their Eligible Family Dependents. Eligible Family Dependents are described in section 16, Definitions. If your Plan includes coverage for Family Dependents, it will be indicated in the Employer/Group Agreement. Contact Customer Service or your Employer’s benefits office to find out if your Plan includes coverage for Family Dependents.

Each Eligible Family Dependent is eligible for coverage on:
1. The date specified in the Employer Group/Agreement on file with your Employer for the newly Eligible Employee if the individual is an Eligible Family Dependent who may be covered on that date;
2. For any Eligible Family Dependents acquired on the date of the Subscriber’s marriage, on the first day of the calendar month following our receipt of the enrollment request; or on an earlier date as agreed to by us;
3. The date of birth of the biological child of the Subscriber or Subscriber's spouse;
4. The date a child is placed with the Subscriber or the Subscriber's spouse for the purpose of adoption by the Subscriber or the Subscriber's spouse;
5. The date the Subscriber or the Subscriber’s spouse is required to provide health coverage to a child under a qualified medical child support court or administrative order; or
6. The date on which legal guardianship status begins.

3.2.2 Additional Requirements for Eligible Family Dependent Coverage
An Eligible Employee may cover her or his Eligible Family Dependents ONLY if she or he is also covered, and we receive her or his completed enrollment form requesting Dependent coverage.

3.2.3 Eligible Family Dependent Enrollment
You must enroll Eligible Family Dependents on forms provided and/or accepted by us. No Eligible Family Dependent will become a Member until we approve that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within the time period specified in the Employer/Group Agreement after becoming eligible as indicated in section 3.2.1 (see section 3.2.4 regarding newborn and adopted children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 3.4.

3.2.4 Newborn Eligibility and Enrollment
A newborn or adopted child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption as long as enrollment occurs within 60 days from birth or placement and additional Premium, if any, is paid to us. If the enrollment and payment of additional Premium, if any, are not accomplished within this time period, no medical Services will be covered for the child. Enrollment after this time period may be accomplished as outlined in sections 3.2.3 and 3.4.

3.2.5 Open Enrollment Period
Your Employer will provide an Open Enrollment Period each Contract Year. The Effective Date of Coverage for new Members who enroll during the Open Enrollment Period is the first day of the Contract Year for which they enroll.

3.2.6 Changes in Eligibility
When an eligibility change occurs, you need to make sure we are notified of the change. Address changes can be made over the phone by calling Customer Service or by visiting our website.

For the following changes, you, as the Subscriber, must obtain an enrollment form from your Employer’s benefit office. You need to submit this form to your Employer for you and all your Eligible Family Dependents when:

- You marry and wish to enroll your new Spouse;
- A Dependent’s limiting age occurs; or
- You or one of your Dependents has a legal name change.

If you have questions regarding eligibility changes, please contact Customer Service.
3.2.7 Members No Longer Eligible for Coverage
If you divorce or are legally separated, your Spouse is no longer eligible for coverage as a Dependent. You must disenroll your Spouse as a Dependent from your Plan at the time the divorce or legal separation is final, or at the time specified on your Employer/Group Agreement. Your Spouse’s children will be able to continue coverage under the plan so long as the children continue to qualify as your Eligible Family Dependents.

You must inform your Employer of these changes by completing a new enrollment form. Check with your Employer’s benefits office or contact Customer Service to determine the effective date of any enrollment or disenrollment.

Those who no longer qualify as your Eligible Family Dependents may be eligible to continue coverage as described under sections 11 and 12. Ask your Employer or call Customer Service for continuation coverage eligibility information.

3.3 OUT-OF-AREA DEPENDENTS

3.3.1 Change of Status
Out-of-Area Dependents will become ineligible for Out-of-Area Dependent coverage under the following circumstances:
1. If the Out-of-Area Dependent moves into the Service Area as a resident; or
2. If the Out-of-Area Dependent resides with the Subscriber or out-of-area Subscriber; or
3. If we extend the Service Area to include the location where the Out-of-Area Dependent resides.

Eligible Family Dependents may change their in-area or out-of-area status by contacting us and completing a status change enrollment form. Retroactive changes are limited to 30 days. See section 4.5 for additional information regarding Out-of-Area Dependents.

3.4 SPECIAL ENROLLMENT PERIODS
If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your spouse) during a previous enrollment period (as stated in sections 3.1 and 3.2), you may be eligible to enroll yourself or the Eligible Family Dependent during a “special enrollment period” provided that you request enrollment within 30 days of the qualifying event and meet the applicable requirements stated in this section.

In instances where an Eligible Family Dependent of a Subscriber qualifies for a “special enrollment period,” the Subscriber and the Eligible Family Dependent may:
• Enroll in the coverage currently elected by the Subscriber; or
• If the Employer has elected to provide more than one benefit option, enroll in any benefit option for which the Subscriber and Eligible Family Dependent is eligible.
3.4.1 Loss of Other Coverage

If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your spouse) because of other health coverage and you lose that other coverage, we will provide a “special enrollment period” for you and/or your Eligible Family Dependent if:

a) The person was covered under a group health plan or had other health coverage (includes benefits consisting of medical care under any hospital or medical services policy or certificate, or HMO) at the time coverage under this policy was first offered to the person; and

b) The person stated in writing that coverage under such group health plan or health coverage was the reason for declining enrollment; but only if we required such a statement and provided the person with notice of such requirement (and the consequences of such requirement) at such time; and

c) Such coverage:

- was under a COBRA Continuation provision and the coverage under such a provision was exhausted, except when the person failed to pay timely premium, or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact); or

- was not under a COBRA Continuation provision and the coverage was terminated as a result of:
  1. The individual’s loss of eligibility for the coverage; including as a result of legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment; except when the person failed to pay timely premium or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact); or
  2. The individual’s loss of eligibility for coverage under the Children’s Health Insurance Program (CHIP), Medicaid, Medicare, TRICARE, Indian Health Service or domestic or foreign publicly sponsored or subsidized health plan; including but not limited to the Oregon Health Plan (OHP); and the individual applies for coverage under this Personal Option Plan within 63 days of the termination of such coverage; or
  3. The termination of contributions toward such coverage by the current or former Employer; or
  4. The individual incurring a claim that exceeds the lifetime limit on all benefits; and the individual applies for coverage under this Personal Option Plan within 30 days after the claim is denied.

**Effective Date:** Coverage under this Personal Option Plan will take effect on the first day after the other coverage ended.

3.4.2 New Dependents

If you were eligible to enroll as a Subscriber under this Personal Option Plan, but did not enroll during a previous enrollment period, and a person becomes your Eligible Family Dependent through marriage, birth, adoption or placement for adoption; we will provide a “special enrollment period” during which you and your Eligible Family Dependent(s) may enroll under this Personal Option Plan.

The “special enrollment period” shall be a period of 30 days and begins on the later of:

- the date Dependent coverage is made available under this Personal Option Plan; or
- the date of the marriage, birth, or adoption or placement for adoption.
Effective Date:
- in the case of marriage, on the first of the calendar month following our receipt of the enrollment request, or on an earlier date as agreed to by us; or
- in the case of a Dependent’s birth, on the date of such birth; or
- in the case of a Dependent’s adoption or placement for adoption, the date of such adoption or placement for adoption; or
- in the case of legal guardianship of a Dependent, the date such legal guardianship status begins.

3.4.3 Court Orders
If you were eligible to enroll as a Subscriber under this Personal Option Plan, but did not enroll during a previous enrollment period, and a court orders you to provide coverage for a spouse or minor child under your Health Benefit Plan, we will provide a “special enrollment period” for you and the spouse or minor child you are ordered to provide coverage for if you request enrollment within 30 days after the issuance of the court order.

Effective Date: The date specified in the court order.

3.4.4 Premium Assistance
If you or your Eligible Family Dependent were eligible to enroll under this Personal Option Plan but did not enroll during a previous enrollment period, and you or your Eligible Family Dependent becomes entitled to group health plan premium assistance under a Medicaid-sponsored or Children’s Health Insurance Program (CHIP)-sponsored arrangement such as the Family Health Insurance Assistance Program (FHIAP), we will provide a “special enrollment period” for you and your Family Member(s) if you request enrollment within 60 days after the date of entitlement.

3.5 MEMBERS AFFECTED BY A REPLACEMENT OF GROUP COVERAGE
If you were covered under the Employer’s prior group policy on the date of termination of that group policy and the Employer replaces that group policy with this Personal Option Plan with no lapse in coverage and you are eligible for and enroll in coverage under this Personal Option Plan, then the following will govern such coverage:
- The minimum level of benefits to be provided by us shall be the applicable level of benefits of this Personal Option Plan reduced by any benefits payable by the prior contract or policy. Such coverage will be provided by us until the date on which your coverage terminates as described in section 10.
- In applying any Deductibles or benefit Exclusion Periods of the prior plan, we will credit any applicable Deductibles actually incurred by you and will credit the time period satisfied towards any applicable benefit Exclusion Periods. This means the Deductible credit shall be given only to the extent the expenses are recognized under the terms of this Personal Option Plan and are subject to a similar Deductible.
- If you are confined in a Hospital on your Effective Date of Coverage and the Employer replaces a prior Oregon-based group policy or contract with this Personal Option Plan with no lapse in coverage, benefit availability for Covered Services under this Personal Option Plan will be affected. Specifically, you will continue to receive benefits for Covered Services from the prior group policy until you are discharged from the Hospital or until the limits of the prior group policy have been reached, whichever is earlier.
3.6 LEAVE OF ABSENCE AND LAYOFFS

A Subscriber on an Employer-approved leave of absence, for any reason, may continue to be covered under this Personal Option Plan as though actively at work, at the Employer’s option, for a period of time as stated in the Employer/Group Agreement. Absences extending beyond this time period will be subject to sections 11 and 12.

A Subscriber who has been laid off and rehired shall be covered as stated in the Employer/Group Agreement. An enrollment application must be completed by the Eligible Employee and received by us within the time period stated in the Employer/Group Agreement.

For the Subscriber, a leave of absence granted under the federal Family and Medical Leave Act (FMLA), the Uniformed Services Employment and Reemployment Rights Act (USERRA), or similar state laws is administered in accordance with those Acts and this Personal Option Plan.

- The subscriber’s absence must be within the Employer’s policies and practices as defined in the Employer/Group Agreement;
- The Employer’s leave of absence policy must comply with the Oregon FMLA, the federal FMLA; or the USERRA;
- The Employer’s work-related disability policy must comply with Workers’ Compensation or similar laws; and
- The Employer must continue to pay the subscriber’s and any covered dependent’s monthly premium to the health plan. However, the subscriber may be responsible for paying a portion or all of his/her premium amount to his/her Employer in accordance to the Employer’s leave of absence or work-related disability policies and practices.

Coverage for a Subscriber and any Eligible Family Dependents may be continued while the subscriber is on Employer-approved leave of absence or while away from work due to a work-related disability.
4. HOW TO USE YOUR PLAN

Our goal is maintaining your health by promoting wellness and preventive care. We encourage you to work closely with one provider, your Personal Physician/Provider, who can provide most of your care, suggest specialist care and arrange for Hospital care or diagnostic testing.

This section describes how to use this plan and how benefits are applied. It is important to remember that your benefits are determined according to the plan option that your Employer has elected and the kinds of Services and providers that you have selected for your care. The level of benefits for Covered Services is shown in the Benefit Summary and described in sections 5 and 6 of this Personal Option Plan.

4.1 PARTICIPATING PROVIDERS

Providence Health Plan has contractual arrangements with certain physicians/providers, hospitals and facilities located in our Oregon and southwest Washington service area. Our agreements with these “Participating Providers” enable you to receive quality health care for a reasonable cost.

For benefits to be covered, you must receive Services from Participating Providers. It is your responsibility to verify whether or not a physician/provider, hospital or other facility is participating with us even if you have been directed or referred for care by a Participating Provider.

4.1.1 Nationwide Network of Participating Providers

Providence Health Plan also has contractual arrangements with certain Qualified Practitioners, Hospitals and facilities nationwide. These arrangements allow you to receive Services when using Participating Providers, even when you are outside the Providence Health Plan Service Area.

4.1.2 Choosing a Participating Provider

To choose a Participating Provider, or to verify if a provider is a Participating Provider, please refer to our Provider Directory, available online at www.providence.org/healthplans (select “Personal Option” as your plan type).

Your Participating Provider will work with Providence Health Plan to arrange for any Prior Authorization requirements that may be necessary for certain Covered Services. For more information on Prior Authorization, see section 4.6.

4.1.3 Indian Health Services Providers

Native American Members may also access Covered Services from Indian Health Services (IHS) facilities at no greater cost than if the Services were accessed from a Participating Provider. For a list of IHS facilities, please visit the IHS website at www.ihs.gov, or contact the regional IHS office at:

Portland Area Indian Health Service
1414 NW Northrup St., Ste. 800
Portland, OR 97209

Telephone: 503-414-5555
4.2 **THE ROLE OF A PERSONAL PHYSICIAN/_PROVIDER**

To encourage optimum health, we promote wellness and preventive care. We also believe wellness and overall health is enhanced by working closely with one physician or provider – your Personal Physician/Provider. He or she can provide most of your care and, when necessary, coordinate care with other providers in a convenient and cost-effective manner. We recommend that upon joining Providence Health Plan you and each of your family members choose a Participating Personal Physician/Provider as soon as possible.

Please see your Benefit Summary for coverage of preventive Services from a Participating Personal Physician/Provider.

4.2.1 **Personal Physicians/Providers**

A Personal Physician/Provider is a Qualified Practitioner who specializes in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a physician assistant, when providing services under the supervision of a physician; who agrees to be responsible for the continuing medical care by serving as case manager. Adult female Members also may choose a physician specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women’s health care as their Personal Physician/Provider.

Personal Physicians/Providers provide preventive care and health screening, medical management of many chronic conditions, allergy shots, treatment of some breaks and sprains, and care for many major illnesses and nearly all minor illnesses and conditions. Many Personal Physicians/Providers offer maternity care and minor outpatient surgery as well.

**IMPORTANT NOTE:** Participating Personal Physicians/Providers have a special agreement with us to serve as a case manager for your care. This means not all of our Participating Providers with the specialties listed above are Participating Personal Physician/Providers. Please refer to the Provider Directory, available online, for a listing of designated Participating Personal Physicians/Providers or call your Customer Service team to request a hard copy.

4.2.2 **Established Patients with Personal Physicians/Providers**

If you and your family already see a provider you may want to check the provider directory to see if your provider is a Participating Personal Physician/Provider for Providence Health Plan. If your provider is participating with us, let his or her office know you are now a Providence Health Plan Member.

4.2.3 **Selecting a New Personal Physician/Provider**

We recommend that you choose a Personal Physician/Provider from our Provider Directory, available online, for each covered family member. Call the provider’s office to make sure he or she is accepting new patients. It is a good idea to have your previous physician or provider transfer your medical records to your new Personal Physician/Provider as soon as possible. The first time you make an appointment with your Personal Physician/Provider, let him or her know you are now a Providence Health Plan Member. On your first visit, make a list of questions or information you would like to discuss with your new Personal Physician/Provider, including the following:

- What are the office hours?
- How can I get medical advice after hours?
- What do I do in an emergency?

Let your Personal Physician/Provider know if you are under a specialist’s care as well as if you are currently taking any ongoing prescription medications.
4.2.4 Changing Your Personal Physician/Provider

You are encouraged to establish an ongoing relationship with your Personal Physician/Provider. If you decide to change your Personal Physician/Provider, please remember to have your medical records transferred to your new Personal Physician/Provider.

4.2.5 Office Visits

**Personal Physicians/Providers**

We recommend you see your Personal Physician/Provider for all routine care and call your Personal Physician/Provider first for urgent or specialty care. If you need medical care when your Personal Physician/Provider is not available, the physician/provider on call may treat you and/or recommend that you see another provider who specializes in treatment for your condition.

**Other Participating Providers (Specialists)**

Your Personal Physician/Provider will discuss with you the need for diagnostic tests or other specialist services; and may also recommend you see a participating specialist for your condition.

You also may decide to see a participating specialist without consulting your Personal Physician/Provider. Visit our Provider Directory, available online at [www.providence.org/healthplans](http://www.providence.org/healthplans), or call Customer Service to make sure the specialist you choose is a Participating Provider with Providence Health Plan.

If you decide to see a participating specialist on your own, we recommend you let your Personal Physician/Provider know about your decision. Your Personal Physician/Provider will then be able to coordinate your care and share important medical information with your specialist. In addition, we recommend you let your specialist know the name and contact information of your Personal Physician/Provider.

Whenever you visit a participating specialist:

- Bring your Providence Health Plan Member ID Card.
- Understand that in most cases, your out-of-pocket costs will be a percent of the Usual, Customary and Reasonable charges for services. Your provider’s office will send you a bill for the amount you owe. Some providers, however, may ask you to pay an estimate of what you may owe at the time you receive services, and will bill or credit you the balance later. (For certain Employer Group plans, there is a Member Copayment for participating specialist visits instead of a Coinsurance. If you are on one of these plans, you will need to pay your Member Copayment at the time of your visit. Please check your Benefit Summary for your specific coverage information.)

4.3 SERVICES PROVIDED BY NON-PARTICIPATING PROVIDERS

Providence Health Plan may approve and provide reimbursement for Non-Participating Qualified Practitioners and facilities. Benefits for Covered Services by a Non-Participating Provider will be provided as shown in the Benefit Summary when we determine in advance, in writing, that the Non-Participating Provider possesses unique skills which are required to adequately care for you and are not available from Participating Providers.

**IMPORTANT NOTE:** While Providence Health Plan will provide reimbursement for approved Covered Services received from a Prior Authorized Non-Participating Provider, for benefits to be paid you must receive Medically Necessary Covered Services. All treatment, supplies, and medications excluded by this Plan are not covered no matter what type of approved category of provider you see.
4.4 **MOVING INTO OR OUT OF THE SERVICE AREA**

If you or a Family Member permanently moves into or out of the service area, you must immediately notify us and your Employer as such a move may affect your benefits or coverage under this Personal Option Plan. We will determine how this move affects your coverage and will inform you of any changes. If you have Dependent(s) who move in or out of our Service Area, a Change of Status form for those Dependent(s) must be completed and returned to us as soon as possible. This form can be obtained from us or from your Employer. See section 3.3.1 for more information.

4.5 **OUT-OF-AREA DEPENDENTS**

Dependents of a subscriber on a Personal Option Plan who live outside the Providence Health Plan service area (including dependents who are away at school) are eligible to become Out-of-Area Dependent Members. See “Definitions” section 16, for the definition of “Eligible Family Dependent” and “Out-of-Area Dependent.” This section discusses how Enrolled Out-of-Area Dependent Personal Option Plan Members obtain covered services through Providence Health Plan’s enrolled Out-of-Area Dependent benefit.

4.5.1 **Out-of-Area Dependent Enrollment**

To apply for Personal Option Out-of-Area Dependent benefits, complete an Out-of-Area Dependent Enrollment form, available from your Customer Service team. **If you do not complete an Out-of-Area Dependent Enrollment form, your Out-of-Area Dependent will not be covered for Out-of-Area Dependent benefits.**

4.5.2 **Out-of-Area Dependent Coverage**

When you enroll for Out-of-Area Dependent coverage, we will send you an Out-of-Area Dependent Benefit Summary. As stated in your Benefit Summary, a dependent with Out-of-Area benefits may see any provider, in or out of the service area. Please refer to your Out-of-Area Dependent Benefit Summary for detailed Coinsurance or Copayment and annual Out-of-Pocket Maximum information. (For Out-of-Area Dependents who are covered by a government sponsored health plan of a country other than the United States, coverage under this Personal Option Out-of-Area Dependent plan will be secondary and will not replace or duplicate coverage available under the government sponsored plan.) Our payment is based on usual, customary and reasonable (UCR) charges. Charges which exceed UCR charges are your responsibility.

If you have a Supplemental Prescription Drug Benefit (see section 2.5), you must purchase your prescription drugs at one of our participating pharmacies nationwide. A list of our participating pharmacies is available online at [www.providence.org/healthplans](http://www.providence.org/healthplans). You also may contact Customer Service if you need help locating a participating pharmacy near you or when you are away from your home. See your Prescription Drug Benefit Summary for details on your Coinsurance/Copayment and on how to use this benefit. No prescription drug out-of-pocket costs apply to the medical Out-of-Pocket Maximum.

**Payment for Non-Participating Physician/Provider Services (UCR)**

If we have approved a Non-Participating Provider and the Services provided are Medically Necessary Covered Services, we will provide payment according to Usual, Customary and Reasonable charges (UCR). UCR charges do not include sales taxes, handling fees and similar surcharges; such taxes, fees and surcharges are not covered expenses. Charges which exceed UCR are the Member’s responsibility and are not applied to the Out-of-Pocket Maximum.
You will be responsible for costs that are not covered or allowed by your benefits as shown in the following example.

<table>
<thead>
<tr>
<th>Provider’s Status</th>
<th>Participating</th>
<th>Non-Participating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s standard charges</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Allowable charges under this Personal Option Plan</td>
<td>$80 (contracted)</td>
<td>$80 (UCR)</td>
</tr>
<tr>
<td>Plan benefits (for this example only)</td>
<td>$64 (if 80% benefit)</td>
<td>$56 (if 70% benefit)</td>
</tr>
<tr>
<td>Balance you owe</td>
<td>$16</td>
<td>$24</td>
</tr>
<tr>
<td>Additional amount that the provider may bill to you</td>
<td>$-0-</td>
<td>$20 ($100 minus $80)</td>
</tr>
<tr>
<td>Total amount you would pay</td>
<td>$16</td>
<td>$44 ($24 plus $20)</td>
</tr>
</tbody>
</table>

4.5.3 Out-of-Area Dependents and Change of Status

Enrolled Out-of-Area Dependents may change to In-Area or Out-of-Area status by contacting us and completing a status change enrollment form. The change will be effective the date you specify or if no date is specified, on the first of the month following our receipt of the enrollment form. Retroactive changes are limited to 30 days.

4.5.4 Out-of-Area Dependents Prior Authorization

Enrolled Out-of-Area Dependents are responsible for obtaining Prior Authorization from Providence Health Plan prior to receiving certain services from non-participating providers. For further information about Prior Authorization, including a list of these covered services and how to obtain Prior Authorization, see “Covered Services that Require Prior Authorization,” section 4.6.

You must contact us to obtain Prior Authorization for specified Covered Services if the Services are to be received from a Non-Participating Provider. See section 4.6.

Failure to Obtain Prior Authorization:
If you do not obtain a Prior Authorization for Services received from a Non-Participating Provider, as specified in section 4.6, a 50% penalty, not to exceed $2,500 for each Covered Service, will be applied to the claim.

Should we determine that we would have covered the Service had Prior Authorization been obtained, benefits will be applied to the remaining claim balance after the Prior Authorization Penalty is assessed. The penalty does NOT apply to the Deductible, if any, or to the Out-of-Pocket Maximum shown in the Benefit Summary.

4.6 COVERED SERVICES THAT REQUIRE PRIOR AUTHORIZATION

While Prior Authorization is a requirement for coverage of certain Services under this Personal Option Plan, Prior Authorization is not a treatment directive. The actual course of medical treatment that a Member chooses remains strictly a matter between the Member and his/her provider and is separate from the Prior Authorization requirements of this Personal Option Plan. Further, Prior Authorization is not a guarantee of benefit payment under this Personal Option Plan and a Prior Authorization determination does not supersede other specific provisions of this Personal Option Plan regarding coverage, limitations, exclusions and Medically Necessary Services.

Services received from Participating Providers:
When Services are received from a Participating Provider, the Participating Provider is responsible for obtaining Prior Authorization.
Services received from Non-Participating Providers:
When Services are received from a Non-Participating Provider, the Member is responsible for obtaining Prior Authorization. See sections 4.3 and 4.5.4.

Services requiring Prior Authorization:

- All inpatient admissions to a Hospital (not including emergency room care), Skilled Nursing Facility or a rehabilitation facility, all emergency hospitalizations (we need to be notified within 48 hours, or as soon as reasonably possible) and all Hospital admissions for maternity/delivery Services;
- All outpatient surgical procedures;
- All inpatient, residential and day or partial hospitalization treatment Services for Mental Health and Chemical Dependency conditions, as provided in section 5.7;
- All human organ/tissue transplant related Services, as provided in 6.1;
- All Restoration of Head/Facial Structures; Limited Dental Services as provided in section 6.2;
- All PET, CT, CTA, MRI and MRA imaging and Nuclear Cardiac Study Services as provided in section 5.9.8;
- All home health care Services as provided in section 5.9.12;
- All hospice Services as provided in section 5.9.13;
- All medical supplies/devices, prosthetic devices and Durable Medical Equipment in excess of $1,500 as provided in section 5.8;
- All outpatient hospitalization and anesthesia for dental Services as provided in section 6.2.2; and
- All outpatient cardiac rehabilitation Services as provided in section 5.9.1.

We will provide a Prior Authorization form upon oral or written request. If you need information on how to obtain Prior Authorization, please call Customer Service at the number listed on your Member ID Card.

If an Emergency Medical Condition exists which prevents you from obtaining Prior Authorization, we must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, to continue coverage of these Services.

4.7 MEDICAL COST MANAGEMENT

Coverage under this Personal Option Plan is subject to the medical cost management protocols established by us to ensure the quality and cost effectiveness of Covered Services. Such protocols may include Prior Authorization, concurrent review, case management and disease management.

We reserve the right to deny payment for Services that are not Medically Necessary in accordance with the criteria maintained by us. When more than one medically appropriate alternative is available, we will approve the least costly alternative.

We reserve the right to make substitutions for Covered Services under this Personal Option Plan. Substituted Services must:
1. Be Medically Necessary;
2. Have your knowledge and agreement while receiving the Service;
3. Be prescribed and approved by your Qualified Practitioner; and
4. Offer a medically therapeutic value at least equal to the Covered Service that would otherwise be performed or given.

We may disallow a substitute Service at any time by sending a 30-day advance written notice to you and your Qualified Practitioner.
4.7.1 Coverage of New Technology and New Application of Existing Technology

New technologies and new applications of existing technologies are evaluated and approved for coverage when they provide a demonstrable benefit for a particular illness or disease, are scientifically proven to be safe and most effective, and there is no equally effective or less costly alternative.

Emerging and innovative technologies are monitored by Providence Health Plan through review of trend reports from technology assessment bodies, government publications, medical journals, and information provided by providers and professional societies.

A systematic process for evaluating a new technology or new application of an existing technology is proactively initiated when sufficient scientific information is available.

Providence Health Plan has developed standards to guide the evaluation process and to ensure appropriate coverage determinations. New technology must minimally meet the following guidelines to be approved for coverage.

- Technology must improve health outcomes. The beneficial effects must outweigh any harmful effects on health outcomes. It must improve the length of life, ability to function or quality of life.
- Technology must be as beneficial as any established alternative. It should improve the net health outcome as much, or more, than established alternatives.
- Application of technology must be appropriate, in keeping with good medical standards, and useful outside of investigational settings.
- Technology must meet government approval to market by appropriate regulatory agency as applicable.
- Criteria must be supported with information provided by well-conducted investigations published in peer-reviewed journals. The scientific evidence must document conclusions that are based on established medical facts.
- Opinions and evaluations of professional organizations, panels, or technology assessment bodies are evaluated based on the scientific quality of the supporting evidence.

Technology Evaluation Process

A committee of medical directors with physician specialist advisors evaluates all new technology and determines coverage based on evidence for safety and efficacy. The committee relies upon a thorough review of pertinent medical literature and utilizes national technology review services that provide independent analysis of a new technology.

Expedited Review

Requests for coverage of new technology may occur before formal policy has been developed. In these cases, an expedited review is implemented and a decision made on a case-by-case basis. This is separate and distinct from the problem resolution procedure set forth in section 9.
4.8 **MEDICALLY NECESSARY SERVICES**

We believe our Members are entitled to comprehensive medical care within the standards of good medical practice. Our medical directors and special committees of participating providers determine which Services are Medically Necessary, as described in section 16, Definitions. Services that do not meet Medically Necessary criteria will not be covered.

- **Example:** Your provider suggests a treatment using a machine that has not been approved for use in the United States. We probably would not pay for that treatment.

- **Example:** You go to a hospital emergency room to have stitches removed, rather than wait for an appointment in your doctor’s office. The Plan would not pay for that visit.

- **Example:** You stay an extra day in the hospital only because the relative who will help you during recovery cannot pick you up until the next morning. We may not pay for the extra day.

Although a treatment was prescribed or performed by a Qualified Practitioner, it does not necessarily mean that it is Medically Necessary under our guidelines. Obtaining confirmation of coverage from Providence Health Plan beforehand is always recommended.

4.9 **HOW BENEFITS ARE APPLIED**

Benefits are subject to the following provisions, if applicable, as specified in the Benefit Summary:

1. The Deductible;
2. The Copayment or Coinsurance amount; and
3. The benefit limits and/or maximums.

4.10 **DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS**

Most Plans have a Deductible. If your Plan has a Deductible, it will be stated in your Benefit Summary.

Most Plans have an Out-of-Pocket Maximum. If your Plan has an Out-of-Pocket Maximum, it will be stated in your Benefit Summary.

4.10.1 **Understanding Deductibles**

Your Deductible is the dollar amount shown in the Benefit Summary that you are responsible to pay every Calendar Year when receiving most Covered Services before benefits are provided by us. Deductible amounts are payable to your Provider after we have processed your claim.

Certain Covered Services may be covered without a Deductible. Please see your Benefit Summary for information about these Services.

*Individual Deductible:* An individual Deductible is the amount shown in the Benefit Summary that must be paid by a Member before we begin to provide benefits for Covered Services for that Member.

*Family Deductible:* The family Deductible is the maximum Deductible amount, listed in your Benefit Summary, that Family Members must pay. All amounts paid by Family Members toward their individual Deductibles apply toward the family Deductible. When the family Deductible is met, no further individual Deductibles will need to be met by any Family Members.

Your Benefit Summary indicates the minimum number of family Members that must be enrolled on the Plan for the family Deductible to apply. When the number of enrolled family Members is less than the minimum amount indicated in your Benefit Summary, the individual Deductible applies to each enrolled Member.

*Note:* No Member will ever pay more than an individual Deductible before we begin paying for Covered Services for that Member.
Your Costs that Do Not Apply to Deductibles: The following out-of-pocket costs do not apply towards Your Individual and Family Deductibles:

- Services not covered by this Group Contract.
- Services in excess of any maximum benefit limit.
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges.
- Any penalties you must pay if you do not follow Providence Health Plan’s Prior Authorization requirements.
- Copayments or Coinsurance for any Supplemental Benefits your Employer may have purchased, such as prescription drugs, routine vision or alternative care.

Deductible Carry Over: Applicable charges used to meet any portion of the Deductible during the fourth quarter of a Calendar Year will be applied toward the next year’s Deductible.

Members may receive credit toward the satisfaction or partial satisfaction of the Deductible when this Group Contract immediately replaces continuous coverage under a previous plan and the Member or Employer informs us that credit for applicable charges is due.

4.10.2 Understanding Out-of-Pocket Maximums

Out-of-Pocket Maximums are the total amount you will pay out-of-pocket in any Calendar Year for Covered Services received under this Personal Option Plan.

Individual Out-of-Pocket Maximum: Individual Out-of-Pocket Maximum means the total amount of Copayments and Coinsurance that an individual must pay in a Calendar Year, as shown in the Benefit Summary, before we begin to pay 100%* for Covered Services for the individual within that Calendar Year.

Family Out-of-Pocket Maximum: Family Out-of-Pocket Maximum means the total amount of Copayments and Coinsurance that a family must pay in a Calendar Year, as shown in the Benefit Summary, before we begin to pay 100%* for Covered Services for the family. When the combined Copayment and Coinsurance expenses of enrolled Family Members meets the family Out-of-Pocket Maximum, all remaining individual Out-of-Pocket Maximums will be waived for the family for that Calendar Year.

Your Benefit Summary indicates the minimum number of family Members that must be enrolled on the Plan for the family Out-of-Pocket Maximum to apply. When the number of enrolled Family Members is less than the minimum amount indicated in your Benefit Summary, the individual Out-of-Pocket Maximum applies to each enrolled Member.

Note: Once any Member meets the Individual Out-of-Pocket Maximum, Providence Health Plan will begin to pay 100%* for Covered Services for that Member.
Your Costs that Do Not Apply to Out-of-Pocket Maximums: The following out-of-pocket costs do not apply toward your Individual and Family Out-of-Pocket Maximums:

- Services not covered under this Group Contract.
- Services in excess of any maximum benefit limit.
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges.
- Copayments or Coinsurance for a Covered Service if indicated in the Benefit Summary as not applicable to the Out-of-Pocket Maximum.
- Deductibles.
- Copayments or Coinsurance for any Supplemental Benefits your Plan may have such as prescription drugs, routine vision or alternative care.
- Any penalties you must pay if you do not follow Providence Health Plan’s Prior Authorization requirements.

*IMPORTANT NOTE*: Covered Services not applicable to the Out-of-Pocket Maximum are NOT eligible for 100% benefit coverage. The Copayment or Coinsurance for these Services as shown in the Benefit Summary remains in effect throughout the Calendar Year.

4.11 PRE-EXISTING CONDITIONS

Applies only when this Personal Option Plan is issued to a Small Employer, as specified in the Employer/Group Agreement. See your Benefit Summary.

A Pre-existing Condition means any medical condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the enrollment date of the Member. For purposes of this Pre-existing Condition limitation, the enrollment date of a Member is the earlier of the Effective Date of Coverage or the first day of any required Eligibility Waiting Period.

The limitations for a Pre-existing Condition under this Personal Option Plan do not apply to:
(a) Pregnancy;
(b) Genetic information in the absence of a diagnosis of the condition related to such information;
(c) Services provided to a newly born or adopted child who obtains coverage under this Personal Option Plan as described in section 3; and
(d) Members under the age of 19.

Coverage for Pre-existing Conditions is excluded under this Personal Option Plan for a period of six months following the Member’s enrollment date. The period of coverage exclusion, however, will be reduced by the amount of your prior Creditable Coverage if:
1. Your Creditable Coverage is still in effect on your enrollment date under this Personal Option Plan;
or
2. Your Creditable Coverage ended no more than 63 days before your enrollment date under this Personal Option Plan.
4.12 PRIVACY OF MEMBER INFORMATION

Providence Health Plan respects the privacy of our Members and takes great care to determine when it is appropriate to share your personal health information, in accordance with federal and state privacy laws. We use protected health information and may share it with others as part of your treatment, payment for your treatment, and our business operations.

The following are ways we may use or share information about you, consistent with law:

- We will use the information to administer your benefits and help pay your medical bills that have been submitted to us for payment.
- We may share your information with your doctors or Hospitals to help them provide medical care to you (e.g., if you are in the Hospital, we may give them access to any medical records sent to us by your doctor).
- We may use or share your information with others to help manage your health care (e.g., we might talk to your doctor to suggest a disease management or wellness program that could help improve your health).
- We may share your information with individuals who perform business functions for us. We will only share your information if there is a business need to do so and if our business partner agrees to protect the information.
- We may use your information to provide you with information about alternative medical treatments and programs or about health related products and services that you may be interested in (e.g., we sometimes send out newsletters that let you know about “healthy living” alternatives such as smoking cessation or weight loss programs).

We make every effort to release only the amount of information necessary to meet any release requirement and only release information on a need to know basis. Also, wherever feasible, identifiable information is removed from any information shared.

To secure the confidentiality of medical information, we have procedures in place which you can review at www.providence.org/healthplans/policies.

When Member information is used in health studies, identifiable information is not released. All Member-specific information has identifying information removed, and aggregated data are used as early in the measurement process as possible. The privacy of our Members is completely protected.

Our agreements with Participating Providers contain confidentiality provisions that require providers treat your personal health information with the same care.

You have the right to ask us to restrict how we use or disclose your information for treatment, payment or health care operations. You also have the right to ask us to restrict information we may give to persons involved in your care. While we may honor your request for restrictions, we are not required to agree to these restrictions. You also have the right to register a complaint if you believe your privacy is compromised in any manner.

Members may request to see their medical records. Call your physician’s or provider’s office to ask how to schedule a visit for this purpose.

For more information about uses and disclosures of Member information, including uses and disclosures required by law, please refer to our Notice of Privacy Practices. A copy is available at www.providence.org/healthplans/policies or by calling Customer Service.
4.13 **NOTICE OF PROVIDER TERMINATION**

When a Participating Provider whose contract of participation with us terminates, we will notify those Members who we know are under the care of the terminated provider within 10 days of the termination date or of our knowledge of the termination date.

4.14 **CONTINUITY OF CARE**

If you are in an active course of treatment with a Participating Provider whose contract of participation with Providence Health Plan terminates, you may be eligible to obtain Covered Services from that provider for a limited period of time after the contract of participation ends. The maximum period of continuity of care is 120 days or, in the case of pregnancy, 45 days after delivery. In no event will continuity of care apply after your coverage under this Personal Option Plan terminates or if you change to another plan with us that does not qualify for continuity of care.

To receive continuity of care, you need to request it and your provider must agree that continuity of care is necessary and agree to adhere to the terms of the provider contract she/he had with us.

Continuity of care is not available when the provider has retired; has died; no longer holds an active medical license; is on sabbatical; is prevented from continuing to care for patients because of other circumstances; or has been terminated for quality of care issues and has exhausted all contractual appeal rights.
5. COVERED SERVICES

This section describes Services that, when Medically Necessary and not otherwise excluded or limited, are covered under this Personal Option Plan. Your covered benefits are determined by the contract your Employer Group has entered into with Providence Health Plan.

Benefits and Copayments/Coinsurance vary among Employer Groups. Please refer to your Benefit Summary for your Member Copayments/Coinsurance as well as other details of your specific coverage. You can view your Member materials by registering for a myProvidence account (section 2.4) on our website at www.providence.org/healthplans. If Providence Health Plan is required by law to modify your benefits, you will be notified in writing of the changes.

You must use Participating Providers to receive the covered services listed in this section, unless you are an Enrolled Out-of-Area Dependent or have received Prior Authorization to receive services from a Non-Participating Provider.

If your Employer is a Small Employer, your Plan includes a Pre-existing Condition Exclusion period. See your Benefit Summary and section 4.11.

See section 6 (Limited Covered Services) for the specific coverage provisions that apply to the following:

- Human Organ/Tissue Transplants;
- Restoration of Head/Facial Structures and Limited Dental Services;
- Temporomandibular Joint (TMJ) Services;
- Surgery and anesthesia for dental Services; and
- Tobacco use cessation services.

5.1 PROVIDER SERVICES

5.1.1 Office Visits, Inpatient and Outpatient Hospital Visits, and Home Visits

Office visits, inpatient and outpatient Hospital visits and home visits with a Participating Provider are covered as shown in your Benefit Summary. Copayments and Coinsurances, as shown in your Benefit Summary, apply to all provider visits except those that: (a) are part of a course of maternity care; (b) are for conditions for which this Personal Option Plan contains a separate and specific Copayment or Coinsurance amount; or (c) are ancillary to the visit and are billed separately by the Participating Provider. Services provided by your Participating Provider during your visit may have an additional Member financial responsibility.

For example – You see your Personal Physician/Provider for an office visit and during your visit your provider swabs your throat for a throat culture. You would pay your office visit Copayment or Coinsurance and also would need to pay the Laboratory Services Copayment or Coinsurance for the throat culture. See your Benefit Summary for details.

Your Benefit Summary also lists different Copayments or Coinsurance that may apply for other specific services, such as allergy shots, services for TMJ and maternity care. See your Benefit Summary for details.

If you are unable to keep a scheduled office appointment with your provider, please try to notify that office in advance. If not, you may be charged for the missed appointment. Providence Health Plan will not cover this expense.
5.1.2 E-visits

E-visits are covered in full and must be received from Participating Providers.

Not all Participating Providers offer E-visits. Medical doctors (M.D.), doctors of osteopathy (D.O.), nurse practitioners (N.P.) and physician assistants (P.A.) are the only categories of providers who may be approved for E-visits. Participating Providers who are authorized to provide E-visits have agreed to use Internet security technology approved by us to protect your information from unauthorized access or release.

To be eligible for the E-visit benefit, you must have had at least one prior office visit with your Participating Provider within the last 12 months.

Covered E-visits include, but are not limited to:
1. Communications of a new or existing diagnosis or treatment when the equivalent service received through an office visit would have led to a claims submission to be covered by us;
2. Communications by the Participating Provider about the management of complex chronic conditions that require extensive education and ongoing monitoring;
3. Communications of treatment for relapses of a previous condition that involve extended dialogue and significant physician time and judgment;
4. Discussion of lab results that require significant changes in medication or further testing; and
5. Extended counseling when person-to-person contact would involve an unwise delay.

Examples of e-mail communications that do not qualify as E-visits include, but are not limited to:
1. Renewing prescriptions;
2. Scheduling tests;
3. Scheduling appointments;
4. Reporting normal test results;
5. Recommending a referral to another physician;
6. A consultative message exchange from a patient who is seen in-person immediately afterward as a result of the consultative message;
7. A brief follow-up of an office visit, medical procedure or other treatment to confirm stable condition;
8. A brief discussion to confirm stability of a chronic problem and continuity of present management of the problem; and
9. All communications in connection with Mental Health or Chemical Dependency Covered Services (as provided in section 5.7).

5.1.3 Telemedical Services

Telemedical Services are covered at the applicable benefit level for the Service, as shown in the Benefit Summary, had the Service been received in person provided that the Service:

- Is Medically Necessary;
- Does not duplicate or supplant a Service that is available to the patient in person;
- Is provided by a Qualified Practitioner;
- Originates at a qualified site, such as a Hospital, rural health clinic, federally qualified health center, physician’s office, community mental health center, skilled nursing facility, renal dialysis center, or public health services center; and
- Is delivered through a two-way video communication that allows the Qualified Practitioner to interact with the Member receiving the Service who is at an originating site.
5.1.4 Administration of Anesthesia and Surgical Procedures
Benefits include the administration of anesthesia and surgical procedures, including assistant surgeon and post-operative care.

5.2 PREVENTIVE SERVICES

Preventive Services are covered as shown in the Benefit Summary. For preventive Women’s Health Care Services, see section 5.3.

In accordance with the Patient Protection and Affordable Care Act of 2010 and related legislation, your Plan covers the following Services in full when received from Participating Providers:

- Services rated “A” or “B” by the U.S. Preventive Services Task Force;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children and adolescents as supported by the Health Resources and Services Administration; and
- Preventive care and screenings for women as supported by the Health Resources and Services Administration.

Note: Additional plan provisions apply to some Services (e.g., routine physical examinations and well-baby care must be received from a Participating Personal Physician/Provider, see section 5.2.1).

5.2.1 Physical Examinations and Well-Baby Care

Periodic health exams and well-baby care Services are covered only when you receive these services from a Personal Physician/Provider. These services are covered as stated in your Benefit Summary. Your provider will determine which tests are necessary for your physical exam according to your medical history and your current health status. More frequent exams will be covered if your provider determines that they are necessary. Vision and hearing screening services are covered when performed during a periodic health examination or well-baby care examination. In order for a child to be eligible for benefits for routine newborn baby care, the child must be properly enrolled as outlined in section 3. Ancillary Services such as immunizations are covered under the specified benefit level when billed separately by the provider.

Recommended guidelines:

**Infants up to 24 months:**
- Up to eight well-baby visits.

**Children:**
- 2 years through 6 years: One exam every year.
- 7 years through 19 years: One exam every two years.

**Adults:**
- 20 years through 29 years: One exam every five years.
- 30 years through 49 years: One exam every two years.
- 50 years and older: One exam every year.

If, at the time of your routine physical examination or well-child care, you need paperwork completed for a third party such as school, camp, team sports, etc., your provider may charge you a fee to complete the paperwork. We will not cover this additional fee.
5.2.2 Immunizations and Vaccinations

Benefits for immunizations and vaccinations are provided in accordance with accepted medical practice. Visits to your Qualified Practitioner’s office or participating pharmacy for immunizations or injections are subject to the Copayment or Coinsurance shown in the Benefit Summary.

Covered Services do not include immunizations or vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel.

5.2.3 Prostate Cancer Screening Exams

Benefits for prostate cancer screening examinations include a digital rectal examination and a prostate-specific antigen test, biennially for men 50 and older, or as recommended by the Participating Provider for men designated high risk.

5.2.4 Colorectal Cancer Screening Exams

Benefits for colorectal cancer screening examinations for Members 50 and older include:

- One fecal occult blood test per year, plus one sigmoidoscopy every five years;
- One colonoscopy every 10 years; or
- One double contrast barium enema every five years.

Screening examinations and lab tests for Members designated high risk are covered as recommended by the Participating Provider.

For members age 50 and older:
- All Services for colorectal cancer screenings and exams are covered in full.

For members under age 50:
- All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery Benefit. Fecal occult blood tests and double contrast barium enemas are covered under the Lab Services benefit.

5.2.5 Preventive Services for Members with Diabetes

Preventive Services benefits for Members diagnosed with either insulin dependent or non-insulin dependent diabetes mellitus include:

- An annual dilated retinal exam by a qualified participating eye care specialist;
- An annual glycosylated hemoglobin (HbAlc) test; urine test to test kidney function; blood test for lipid levels as appropriate; visual exam of mouth and teeth (dental visits are not covered); foot inspection; and influenza vaccine by a Participating Provider; and
- A pneumococcal vaccine every five years.

See section 5.9.9 for coverage of Diabetes Self-Management Services.

5.3 WOMEN’S HEALTH CARE SERVICES

Women may choose to receive Women’s Health Care Services from a Personal Physician/Provider or a Women’s Health Care Provider. Women’s health care providers include physicians specializing in obstetrics, some Personal Physicians/Providers (if they provide obstetric services), nurse practitioners, certified nurse midwives or physician assistants specializing in women’s health care.

Note: Women’s health care Services received from a naturopath or any other alternative care provider are not Covered Services under this plan.
5.3.1 Gynecological Examinations
Benefits for gynecological examinations include breast, pelvic and Pap examinations once every calendar year, or more frequently for women who are designated high risk. Family planning Services are separate (see section 5.3.3). Benefits also include follow-up exams for any medical conditions discovered during an annual gynecological exam that require additional treatment.

5.3.2 Mammograms
Mammograms are covered on an annual basis for women over 40 years of age, or as recommended by the Participating Provider or Participating Women’s Health Care Provider for women who are designated high risk.

5.3.3 Family Planning Services
Benefits include counseling, exams, and services for voluntary family planning. Note: If your Benefit Summary reads “Small Group Basic Plan,” you do not have family planning coverage.

**Covered Services and supplies include:**
- Intrauterine device (IUD)* insertion and removal.
- Medical exams and consultation for family planning.
- Depo-Provera to prevent pregnancy.
- Diaphragm devices.
- Removal of Norplant, when determined to be medically necessary.
- Oral contraceptives (birth control pills) are covered only if your Employer has purchased the Supplemental Prescription Drug Benefit, and are subject to the terms and limitations of the supplementary coverage.

*IUDs and diaphragms are covered under your medical supply benefit, see section 5.8.1.

5.3.4 Maternity Services
Your benefits include coverage for comprehensive maternity care.

For most Employer Group plans, there is one Member Copayment per pregnancy for all prenatal/postnatal office visits and delivery Services. This Copayment does not apply to other Covered Services, such as laboratory and X-ray, which you may receive for your maternity care. The specific Coinsurance or Copayment for each of these services will apply instead. Please refer to your Benefit Summary for details.

**Covered Services include:**
- Prenatal care by your physician, provider or certified nurse midwife.
- Delivery at an approved facility or birthing center.
- Postnatal care, including complications of pregnancy and delivery.
- Emergency treatment for complications of pregnancy and unexpected pre-term birth.
- Newborn nursery care* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within timeframes outlined in Newborn Eligibility and Enrollment, section 3.2.4.

*Newborn nursery care is a facility Service covered under your Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in your Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under your Provider Inpatient visit benefit.
IMPORTANT NOTE: Maternity Services for a Member who is serving as a surrogate parent are covered, except to the extent that such Services are payable under the surrogate parenting contract or agreement.

The services of a lay, Direct Entry or Certified Professional midwife are not covered.

Length of maternity hospital stay: Your services include a hospital stay of a minimum of 48 hours for a normal vaginal delivery, and a minimum of 96 hours for a caesarean delivery. You will not be discharged from the hospital sooner than these guidelines, unless you choose to be. You and your physician/provider will determine the length of your hospital stay and follow-up care based on accepted medical practice.

Maternity support services: Members may attend a class to prepare for childbirth. The classes are held at participating hospitals. Call the Providence Resource Line at 503-574-6595 or visit www.providence.org/classes for information on classes, specific dates, locations, registration and prices. Classes vary by geographic area. In addition, Members with high-risk pregnancies may receive support services through care or case management. A care manager may be a social worker and/or a registered nurse.

5.4 HOSPITAL AND SKILLED NURSING FACILITY SERVICES

A per-admission Copayment/Coinsurance or Deductible, if applicable, will be applied once per Confinement, even if you are treated in more than one Hospital and/or Skilled Nursing Facility.

Covered Services do NOT include care received that consists primarily of:
1. Room and board and supervisory or custodial Services.
2. Personal hygiene and other forms of self-care.
3. Non-skilled care for senile deterioration, mental deficiency, or developmental disability.

In all cases the following are specifically excluded from the Hospital and Skilled Nursing Facility benefit:
1. Private duty nursing or a private room unless prescribed as Medically Necessary or otherwise Prior Authorized.
2. Take-home medications, supplies and equipment.
3. Personal items such as telephone, radio, television and guest meals.

5.4.1 Hospital Services

Benefits are provided as shown in your Benefit Summary.

When your Participating Provider and Providence Health Plan determine you need hospitalization, arrangements will be made for you to be admitted to a participating hospital.

For Enrolled Out-of-Area Dependent Members: You are responsible for making sure inpatient hospitalization services are Prior Authorized by us before receiving this care from a non-participating hospital.
Only medically necessary hospital services are covered. Covered inpatient services received in a hospital are:

- Acute (inpatient) care, when medically necessary.
- A semi-private room (unless a private room is medically necessary).
- Coronary care and intensive care, when necessary.
- Isolation care, when necessary.
- Hospital services and supplies necessary for treatment and furnished by the hospital, such as operating and recovery rooms, anesthesia, dressings, medications, whole blood and blood products, oxygen, X-ray, and laboratory services during the period of inpatient hospitalization. (Personal items such as guest meals, slippers, etc., are not covered.)

Providence Health Plan employs professional clinical staff who may review services you receive in the hospital. They may review your care to determine medical necessity, to make sure that you had quality care and to ensure that you will have proper follow-up care.

Your provider will determine your medically appropriate length of stay. If you choose to stay in the hospital longer than your physician advises, you will be responsible for the cost of additional days in the hospital.

### 5.4.2 Skilled Nursing Facility

Benefits are provided as shown in the Benefit Summary for Covered Services from a Skilled Nursing Facility. Services must be Prior Authorized by us and prescribed by your Participating Provider in order to limit Hospital Confinement by providing convalescent skilled medical and nursing Services which cannot be adequately provided through a home health program.

### 5.4.3 Inpatient Rehabilitation Services

Benefits are provided for physical, occupational and speech therapy Covered Services as shown in the Benefit Summary for inpatient rehabilitation to restore or improve lost function following illness or injury. If a Member is hospitalized when rehabilitative Services begin, rehabilitative benefits will begin on the day treatment becomes primarily rehabilitative. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition. Benefits are subject to the limits specified in the Benefit Summary.

### 5.4.4 Observation Care

Benefits are provided, as shown in the Benefit Summary, for Covered Services provided by the Hospital or the Qualified Practitioner while you are held in the Hospital for observation. Observation care includes the use of a bed and periodic monitoring which are reasonable and necessary to evaluate your condition as an outpatient or determine the need for possible admission to the hospital as an inpatient. In general, the duration of observation care does not exceed 24 - 48 hours. Observation care for greater than 48 hours without inpatient admission is generally considered not Medically Necessary and may be subject to medical review.
5.5 **EMERGENCY CARE SERVICES**

Benefits for Emergency Services are provided as described below and shown in the Benefit Summary. Emergency Care Services are provided both in and out of the Service Area. If an emergency situation should occur, you should take immediate action and seek prompt medical care. You should call 911, or the emergency number listed in the local telephone directory or go to the nearest Hospital emergency department.

5.5.1 Emergency Care

A medical emergency is a sudden unexpected illness or injury that you believe would place your life in danger or cause serious damage to your health if you do not seek immediate medical treatment. Medical emergencies include, but are not limited to:

- Heart attack
- Stroke
- Poisoning
- Loss of consciousness
- Unexpected premature childbirth
- Acute abdominal pain
- Severe chest pain
- Serious burn
- Bleeding that does not stop
- Medically Necessary detoxification

Coverage is provided without Prior Authorization for Emergency Medical Screening Exams and stabilization of an Emergency Medical Condition. Hospitalization for an Emergency Medical Condition requires notification to Providence Health Plan within 48 hours, or as soon as reasonably possible following the onset of treatment in order for coverage to continue.

The definition of an “Emergency Medical Condition” is a medical condition that manifests itself by symptoms of sufficient severity that a prudent lay person, possessing an average knowledge of health and medicine, would reasonably expect that failure to receive immediate medical attention would place the health of a person (or a fetus in the case of a pregnant woman) in serious jeopardy.

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

“Emergency Medical Screening Exams” include medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.

Your Plan benefits cover Emergency Services in the emergency room of any Hospital. **Emergency room Services are covered when your medical condition meets the guidelines for emergency care as stated above. Coverage includes Services to stabilize an Emergency Medical Condition and Emergency Medical Screening Exams.**

If you or a Family Member believes that immediate assistance is needed for an Emergency Medical Condition, **call 911 or go to the nearest emergency room.** Tell the emergency personnel the name of your Personal Physician/Provider and show them your Member ID Card.

Call your Personal Physician/Provider any time, any day of the week, your Personal Physician/Provider or the provider-on-call. He or she will tell you what to do and where to go for the most appropriate care.

You are responsible for the emergency Services Copayment/Coinsurance, as shown in the Benefit Summary, whenever you receive Services in an emergency room, unless you are admitted to a Hospital within 24 hours and the hospitalization is otherwise covered under the Plan. Please be prepared to pay your Copayment/Coinsurance, at the time you receive care. You are responsible for the Copayment/Coinsurance for each Hospital emergency room visit.
The Plan does not pay for emergency room treatment for medical conditions that are not medical emergencies. Do not go to the emergency room for care that should take place in your provider’s office. Routine care for sore throats, common colds, follow-up care, and prescription drug requests are not considered to be emergencies.

5.5.2 Emergency Medical Transportation
Benefits include Services for emergency medical transportation by state certified ambulance and certified air ambulance transportation. Ambulance Services are provided for transportation to the nearest facility capable of providing the necessary care or to a facility specified by us.

5.5.3 Emergency Eye Care Services
Covered Services include the initial care for Emergency Medical Conditions resulting from an injury to or illness of the eye(s). Members may receive Services directly from an optometrist or ophthalmologist or from a Hospital emergency room.

5.5.4 Emergency Detoxification Services
Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a Chemical Dependency treatment program, as stated in section 5.7.2, at the time Services are received. Prior Authorization is not required for emergency treatment; however, we or our authorizing agent must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to a Participating Provider for continued inpatient care, the cost of Medically Necessary transportation will be covered. Continuing or follow-up care is not a Covered Service unless Prior Authorized by us or our authorizing agent.

5.6 URGENT/IMMEDIATE CARE SERVICES
Urgent care is treatment you need right away for an illness or injury that is not life threatening. This includes, but is not limited to, minor sprains, minor cuts and burns, and ear, nose, and throat infections. Routine care that can be delayed until you can be seen by a physician or provider in his or her office is not urgent care.

Whenever you need urgent care, call your Personal Physician/Provider first. Your Personal Physician/Provider or the provider-on-call is always available, day or night. He or she may either suggest that you come to the office or go to an emergency room or urgent care center. If you can be treated in your provider’s office or participating urgent care center, your out-of-pocket expense will usually be lower.

You are responsible for the urgent care Copayment/Coinsurance, as shown in the Benefit Summary, whenever you receive Urgent/Immediate Care Services. Please be prepared to pay the Copayment/Coinsurance at the time you receive care. You are also responsible for the applicable Copayment/Coinsurance shown in the Benefit Summary for any ancillary Services received, such as lab tests, that are billed separately by the Qualified Provider.

If you are admitted to a non-participating Hospital, you, or a relative, should call Providence Health Plan within 48 hours or as soon as reasonably possible.

Not all non-participating facilities will file a claim on a Member’s behalf. If you receive urgent care Services from a non-participating facility, you must submit a claim if the facility or provider does not submit it for you. See section 8.1.1.
5.7 MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES

5.7.1 Mental Health Services
President Health Plan

Benefits are provided for Mental Health Services at the same level as and subject to limitations no more restrictive than those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions.

Covered Services include diagnostic evaluation; individual and group therapy; inpatient hospitalization as stated in section 5.4; residential and day or partial hospitalization Services. All inpatient, residential and day or partial hospitalization treatment Services must be Prior Authorized as specified in section 4.6.

In an emergency situation, go directly to a Hospital emergency room. You do not need Prior Authorization for emergency treatment; however, we must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue.

5.7.2 Chemical Dependency Services

Benefits are provided for Chemical Dependency Services at the same level as and subject to limitations no more restrictive than those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions.

Covered Services include diagnostic evaluation; detoxification; individual and group therapy; inpatient hospitalization as stated in section 5.4; residential and day or partial hospitalization Services when they meet the “American Society of Addiction Medicine Placement Guidelines for Substance Related Disorders” (ASAM) criteria.

Prior Authorized is required for all inpatient, residential and day or partial hospitalization treatment Services, as specified in section 4.6.

Treatments involving the use of methadone are a Covered Service only when such treatment is part of a medically-supervised treatment program that has been Prior Authorized.

In an emergency situation, go directly to a Hospital emergency room. You do not need Prior Authorization for emergency treatment; however, we must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue.

5.8 MEDICAL SUPPLIES, MEDICAL APPLIANCES, PROSTHETIC AND ORTHOTIC DEVICES, DURABLE MEDICAL EQUIPMENT (DME) AND HEARING AIDS

Benefits for medical supplies, medical appliances, prosthetic devices, and Durable Medical Equipment (DME) are provided as shown in the Benefit Summary when required for the standard treatment of illness of injury. We may authorize the purchase of an item if we determine the cost of purchasing an item would be less than the overall rental of the item. Services must be prescribed by your Participating Provider.

The reasonable cost of repairing an item is covered as long as this cost does not exceed the purchase of a new piece of equipment or device. Items that are replaced due to loss or negligence are not covered. Items that are replaced due to the availability of a newer or more efficient model are not covered unless we determine otherwise. Repair or replacement is covered if due to normal growth processes or to a change in your physical condition due to illness or injury.
5.8.1 Medical Supplies (Including Diabetes Supplies)

Benefits are shown in the Benefit Summary for medical supplies and diabetes supplies that are described below.

1. Medically Necessary supplies as ordered by your Participating Provider, including, but not limited to, ostomy supplies, IUDs, diaphragms, prescribed needles, syringes and chem strips. Non-sterile examination gloves used by you or your caregiver are NOT a covered medical supply.

2. Diabetes supplies may be purchased through our medical supply providers or at participating pharmacies. Diabetes test strips are limited to 100 per month for insulin dependent Members and 100 every three months for non-insulin dependent Members, unless otherwise prescribed by your Participating Provider.

3. Medically Necessary medical foods for supplementation or dietary replacement including non-prescription elemental enteral formula for home use, when determined to be Medically Necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition. Medical foods are also covered for the treatment of Inborn Errors of Metabolism, as described in section 5.9.10. Medical foods do not include total parenteral nutrition (TPN), which is covered under section 5.9.4.

5.8.2 Medical Appliances

Benefits are shown in the Benefit Summary for the following medical appliances:

1. Casts, braces and supportive devices when used in the treatment of medical or surgical conditions in acute or convalescent stages or as immediate post-surgical care.

2. Initial and replacement contact lenses, intraocular lenses, prescription lenses or standard frame glasses, when required as a result of injury, illness or surgery, such as, but not limited to, cataract, corneal transplant surgery or for the treatment of keratoconus.

3. Rental of an oxygen unit used in the home for Members with significant hypoxemia who are unresponsive to other forms of treatment. The benefit is limited to three months from the initial date of Service unless there is clinical evidence of the need to continue.

4. Removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are subject to the benefit maximum stated in the Benefit Summary, and do not apply to your Deductible.

5. Medical devices that are surgically implanted into the body cavity to replace or aid function. If you receive a procedure to implant a medical device, you will be responsible for any Copayment or Coinsurance for the medical device in addition to any Copayment or Coinsurance for the procedure.

6. Other Medically Necessary appliances as ordered by your Qualified Practitioner.

5.8.3 Prosthetic and Orthotic Devices

Benefits are provided for prosthetic and orthotic devices as shown in the Benefit Summary. Coverage is limited to those prosthetic and orthotic devices that are Medically Necessary and included in the Medicare fee schedule for Durable Medical Equipment, Prosthetics, Orthotics and Supplies. Covered Services include rigid or semi-rigid devices used for supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck or an artificial limb device or appliance designed to replace in whole or in part an arm or a leg; breast implants following mastectomy; artificial eyes; and maxillofacial prosthetic devices for the restoration and management of head and facial structures. (For coverage of removable custom shoe orthotics, see section 5.8.2).
5.8.4 Durable Medical Equipment (DME)
Benefits are provided for DME as shown in the Benefit Summary. Covered Services include Medically Necessary equipment such as a hospital bed, non-motorized wheelchair, ventilator, and similar equipment as approved by us.

Covered Services for DME do not include items that are primarily and customarily used for a non-medical purpose or which are used for environmental control or enhancement (whether or not prescribed by a physician).

5.8.5 Hearing Aids
Medically Necessary external hearing aids and devices, one per ear, prescribed by a licensed audiologist and received from an approved provider are covered for Members younger than 18 years of age and Spouses and Dependent Children, 18 years of age and older, if enrolled in an accredited educational institution. “Hearing aids and devices” are defined as any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries and cords. Coverage is limited to $4,000 every four years. This limit will be adjusted January 1st of each calendar year to reflect the U.S. City Average Consumer Price Index.

5.9 OTHER COVERED SERVICES

5.9.1 Outpatient Hospital Services, Chemotherapy and Radiation Therapy
Benefits are provided as shown in the Other Covered Services section of the Benefit Summary and include outpatient Services at a Hospital, or Outpatient Surgical Facility, dialysis, chemotherapy and radiation therapy. See section 5.9.4 regarding injectable medications. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation and regularly scheduled therapy such as dialysis, chemotherapy, inhalation therapy, or radiation therapy, as ordered by your Participating Provider. We may require that you obtain a second opinion for some elective procedures. If you do not obtain a second opinion when requested, we will not Prior Authorize the Services. For additional information about Prior Authorization, see sections 4.5 and 4.6.

Covered Services under these benefits do not include Services for Short-Term Outpatient Rehabilitation. See section 5.9.3 for those Services.

5.9.2 Self-Administered Chemotherapy
Self-administered chemotherapy agents, including oral medications and injectable medications, are covered when received from a participating retail or specialty pharmacy as shown in the Benefit Summary.

If your Personal Option Plan includes the Supplemental Prescription Drug Benefit, self-administered chemotherapy is covered under that Endorsement when that coverage results in a lower out-of-pocket expense to the Member.

5.9.3 Short-Term Outpatient Rehabilitation
Benefits are included for short-term outpatient physical, occupational and speech therapy Covered Services provided by a participating physician or licensed/registered therapist, as shown in the Benefit Summary, to restore or improve lost function following illness or injury. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member’s condition and are subject to the visit benefit maximum stated in the Benefit Summary. A visit is considered treatment with one provider (e.g., if you see a physical therapist and a speech therapist the same day at the same facility, it counts as two visits as you have received treatment from two providers).
Covered Services under this benefit do NOT include:

1. Adjustments and manipulations of any spinal or bodily area;
2. Exercise programs;
3. Rolfing, polarity therapy and similar therapies;
4. Growth and cognitive therapies, including sensory integration; and
5. Rehabilitation Services provided under an authorized home health care plan as specified in section 5.9.12.

5.9.4 Allergy Shots, Allergy Serums and Injectable Medications

Allergy shots, allergy serum, injectable medications and total parenteral nutrition (TPN) are covered as shown in your Benefit Summary.

Therapy and testing for treatment of allergies including, but not limited to, Services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment are covered only when such therapy or testing is approved by the American Academy of Allergy and Immunology, or the Department of Health and Human Services or any of its offices or agencies.

5.9.5 Podiatry/Foot Services

Benefits include Covered Services of a participating podiatrist or other Participating Provider and are provided as shown in the Physician/Provider Services section of the Benefit Summary. Covered Services include, but are not limited to, the fitting and follow up exam for removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are covered as stated in section 5.8.2 (Medical Appliances). Covered Services do not include routine foot care and the removal of corns or calluses, unless you have diabetes.

5.9.6 Reconstructive Surgery

Reconstructive Surgery is covered for conditions resulting from trauma, infection or other diseases and for congenital deformities and anomalies if there is a resultant functional impairment. Benefits are covered as those Services listed in the Benefit Summary based upon the type of Services received. For Restoration of Head or Facial Structures; Limited Dental Services, see section 6.2.

5.9.7 Reconstructive Breast Surgery

Members who have undergone mastectomy are entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA).

Benefits for Reconstructive Surgery of the breast are covered as those Services listed in the Benefit Summary based upon the type of Services received. Reconstructive Surgery of the breast is covered for:
1. Reconstruction of the involved breast following a mastectomy;
2. Surgery and construction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications of all stages of mastectomy, including lymphedemas.

If you have additional questions about your WHCRA benefits, please contact Customer Service.

5.9.8 Diagnostic Pathology, Radiology Tests and Diagnostic Procedures

Benefits are as shown in the Benefit Summary and include inpatient and outpatient diagnostic pathology (lab), imaging (such as PET, CT, MRI), radiology (X-ray) tests and other Medically Necessary diagnostic procedures. Covered Services include contrast materials (dyes) that may be required for a diagnostic procedure.
5.9.9 Diabetes Self-Management Education Program
Benefits are paid in full for initial self-management education programs obtained at a participating facility. You must be enrolled under this Personal Option Plan throughout the course of the program for benefits to be paid.

5.9.10 Inborn Errors of Metabolism
We will provide benefits for Covered Services as shown in the Benefit Summary based upon the type of Services received for diagnosing, monitoring and controlling inborn errors of metabolism, including, but not limited to: phenylketonuria (PKU); homocystinuria; citrullinemia; maple syrup disease; and pyruvate dehydrogenase deficiency; that involve amino acid, carbohydrate and fat metabolism for which medically standard methods exist, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Covered Services include clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. For coverage of medical foods, see section 5.8.1.

5.9.11 Nutritional Counseling
A maximum of two visits per calendar year are covered for nutritional counseling when Medically Necessary, as determined by the Participating Provider. Fasting and rapid weight loss programs are not covered.

5.9.12 Home Health Care
Benefits for home health care Covered Services are shown in the Benefit Summary and are described below. We will provide benefits for home health care as an alternative to hospitalization with consent of the Member. A Home Health Provider must provide Services at your home under a home health care plan. Nothing in this provision will increase benefits to cover home health care Services that are not otherwise covered under this Personal Option Plan.

Each visit by a person providing Services under a home health care plan or evaluating the need for or developing a plan is considered one home health care visit. Up to four consecutive hours in a 24-hour period of home health care Service is considered one home health care visit. A home health care visit of more than four hours is considered one visit for every four hours or part thereof.

Home health care will not be reimbursed unless your Participating Provider certifies that the home health care Services will be provided or coordinated by a state-licensed or Medicare-certified Home Health Agency or certified rehabilitation agency.

If you were hospitalized immediately prior to the commencement of home health care, the home health care plan must be initially approved by the Participating Provider who was the primary provider of Services during the hospitalization.

If the above criteria are not met, NO benefits will be provided under this Personal Option Plan for home health care.

Rehabilitation Services provided under an authorized home health care plan will be covered as home health care Services.
Home health care benefits do **NOT** include:

1. Charges for mileage or travel time to and from your home;
2. Wage or shift differentials for Home Health Providers;
3. Charges for supervision of Home Health Providers; or
4. Services that consist principally of Custodial Care including, but not limited to, care for senile deterioration, mental deficiency, mental illness, developmental disability or care of a chronic or congenital condition on a long-term basis.

**5.9.13 Hospice Care**

Benefits are included for hospice care as shown in the Benefit Summary and described below. In addition, the following criteria must be met:

1. Your Participating Provider certifies that you have a terminal illness with a life expectancy not exceeding six months; and
2. The Covered Services provided are reasonable and necessary for the condition and symptoms being treated.

When the above criteria are met, we will provide benefits for a full range of Covered Services which a certified hospice care program is required to include. Covered Services include the following:

1. Nursing care provided by or under the supervision of a registered nurse;
2. Medical social Services provided by a medical social worker who is working under the direction of a physician, including counseling for the purpose of helping you and your caregivers adjust to the approaching death;
3. Services provided by your Participating Provider or a physician associated with the hospice program;
4. Durable Medical Equipment, medical supplies and devices, including medications used primarily for the relief of pain and control of symptoms related to the terminal illness;
5. Home health aide Services for personal care, maintenance of a safe and healthy environment and general support to the goals of the plan of care;
6. Rehabilitation therapies provided for purposes of symptom control or to enable you to maintain activities of daily living and basic functional skills; and
7. Continuous home care during a period of crisis in which you require skilled intervention to achieve palliation or management of acute medical symptoms.

Respite care and other Services not specified above are excluded from coverage.
5.10 BASIC PLAN ADDITIONAL COVERED SERVICES

The benefits listed below apply ONLY to Members of the Basic Plan. If your Benefit Summary says “Small Group Basic Plan,” this section applies to you.

5.10.1 Vision and Hearing Screening Exams for Members Through Age 17

Vision-screening and hearing-screening exams by a Personal Physician/Provider are covered as follows for Members through age 17.

**Infants up to 24 months:** Included in well-baby visits (see section 5.2.1).

**Children:**

- 2 years through 6 years: One exam every year.
- 7 years through 17 years: One exam every two years

Covered Services do NOT include the following:

1. Services for laser surgery, radial keratotomy and any other surgery to correct myopia, hyperopia or stigmatic error, vision therapy, orthoptic treatment (eye exercises);
2. Services for routine eye and vision care, refractive disorders, eyeglass frames and lenses, contact lenses; and
3. Hearing aids, including all Services related to the examination and fitting of the hearing aids; except as specified in sections 5.8.5 and 5.10.4.

5.10.2 Focal Surgery for Epilepsy

Benefits for focal surgery for the treatment of epilepsy are included as a surgical Covered Service, as shown in the Physician/Provider Services section of the Benefit Summary.

5.10.3 Children’s Dental Services

Benefits for preventive dental Services for children ages three through 12 are included as shown in the Benefit Summary.

5.10.4 Children’s Hearing Aids

Benefits are included for external hearing aids and hearing devices for children under the age of 18 who experienced hearing loss before age three.
6. LIMITED COVERED SERVICES

There are limitations on the benefits available under this Personal Option Plan for the treatment of certain conditions and the use of certain procedures. These limitations are described in this section.

6.1 HUMAN ORGAN/TISSUE TRANSPLANTS

A transplant is defined as a procedure or series of procedures by which an organ or tissue is either:

- Removed from the body of one person (the donor) and implanted in the body of another person (the recipient who is a Member); or
- Removed from and replaced in the same person’s body (a self-donor who is a Member).

The term transplant does not include Services related to the transfusion of blood or blood derivatives (except hematopoietic stem cells) or replacement of a cornea.

6.1.1 Covered Services

(See also the Exclusion Period in section 6.1.6.)

Covered Services for transplants are limited to Services that:

1. Are determined by us to be Medically Necessary and medically appropriate according to national standards of care;
2. Are provided at a facility approved by us or under contract with us;
3. Involve one or more of the following organs or tissues:
   - Heart
   - Lung
   - Liver
   - Kidney
   - Pancreas
   - Small bowel
   - Autologous hematopoietic stem cell/bone marrow
   - Allogeneic hematopoietic stem cell/bone marrow; and
4. Are directly related to the transplant procedure, including Services that occur before, during and after the transplant procedure.

Covered Services for transplant recipients include medical Services, Hospital Services, medical supplies, medications and prescription drugs while hospitalized, diagnostic modalities, prosthesis, high dosage chemotherapy for stem cell/bone marrow transplants, and travel expenses. Travel expenses are subject to a $5,000 lifetime benefit maximum for transportation, food and lodging. Food and lodging is subject to a $150 per diem. Per diem expenses apply to the $5,000 travel expenses benefit maximum. (Note: Travel expenses are not covered for donors.)

Services for donors are covered when the donor is not eligible for coverage of donation Services under any other Health Benefit Plan or government funding program. Covered Services for donors include:

1. Initial evaluation of the donor and related program administration costs;
2. Preserving the organ or tissue;
3. Transporting the organ or tissue to the transplant site;
4. Acquisition charges for cadaver or live donor;
5. Services required to remove the organ or tissue from the donor; and
6. Treatment of medical complications directly resulting from the surgery performed to obtain the organ or tissue for a period of time not to exceed 30 consecutive days following that surgery.
6.1.2 Benefits for Transplant Facility Services Provided to the Organ Recipient
The Deductible, if any, and Coinsurance or Copayment provisions of this Personal Option Plan are waived, except as follows:

The Member/recipient is responsible for the Coinsurance or Copayment amounts, as shown in the Benefit Summary, for inpatient Hospital Services and for outpatient facility Services that are not billed as a global fee and those amounts will apply to the Member’s Out-of-Pocket Maximum.

6.1.3 Benefits for Outpatient Medications
Outpatient prescription medications for transplant-related Services, including anti-rejection (immunosuppressive) drugs, are not eligible for reimbursement under the medical benefits of this Personal Option Plan. Benefits for outpatient prescription drugs are provided only if this Personal Option Plan includes a prescription drug Supplemental Benefit and those benefits are subject to the terms and limitations of that Endorsement.

6.1.4 Benefits for Physician/Provider Services Provided to the Organ Recipient
Benefits for physician/provider Services are provided as shown in the Benefit Summary. The Member/recipient is responsible for the Coinsurance or Copayment amounts for those Services, as shown in the Benefit Summary, unless those Services are billed as a global fee with the facility Services, and those amounts will apply to the Member’s Out-of-Pocket Maximum.

6.1.5 Prior Authorization
(See also section 4.6.)
To qualify for coverage under this Personal Option Plan, all transplant-related Services, procedures, treatment protocols and facilities must be Prior Authorized, including:

- Initial consultation;
- Evaluation;
- Transplant facilities;
- Donor evaluation;
- Donor Services;
- High-dose chemotherapy administered prior to the transplant;
- HLA typing;
- Travel expenses;
- Pre-transplant care;
- Self-donation Services;
- Transplant Services; and
- Follow-up treatment.

6.1.6 Exclusion Period
No benefits for human organ/tissue transplant Covered Services will be payable during the first 24 months that a Member is covered under this Personal Option Plan unless:

1. The Member has been continuously covered under Creditable Coverage since birth or placement for adoption; or
2. The Member has applicable Creditable Coverage. The duration of the 24-month Exclusion Period will be reduced by the amount of the Member’s prior Creditable Coverage if the most recent period of Creditable Coverage ended within 63 days of the Effective Date of Coverage under this Personal Option Plan. However, Creditable Coverage will only be applied to human organ/tissue transplant Covered Services that were specified as covered under the prior Creditable Coverage, regardless of the level of such prior coverage or the Member’s use of such prior coverage. The Member is responsible for furnishing proof of Creditable Coverage and evidence of the terms of human organ/tissue transplant benefits under the previous coverage.
6.1.7 Exclusions
In addition to the exclusions listed in section 7, the following exclusions apply to human organ/tissue transplants:

- Any transplant procedure performed at a transplant facility that has not been approved by us;
- Any transplant that is Experimental/Investigational, as determined by us;
- Services or supplies for any transplant that are not specified as Covered Services in section 6.1, such as transplantation of animal organs or artificial organs;
- Outpatient medications and anti-rejection (immunosuppressive) drugs, unless this Personal Option Plan includes a prescription drug Endorsement;
- Services related to organ/tissue donation by a Member if the recipient is not a Member or the Member/recipient is not eligible for transplant benefits under this Personal Option Plan; and
- Transplant-related travel expenses for the donor and the donor’s and recipient’s family members.

6.2 RESTORATION OF HEAD/FACIAL STRUCTURES; LIMITED DENTAL SERVICES
Covered Services include restoration and management of head and facial structures, including teeth, dental implants and bridges, that cannot be replaced with living tissue and that are defective because of trauma, disease or birth or developmental deformities, not including malocclusion of the jaw, when Services are Medically Necessary for the purpose of controlling or eliminating pain, or restoring facial configuration or functions such as speech, swallowing or chewing.

Benefits are covered as those Services listed in the Benefit Summary based upon the type of Services received.

Exclusions that apply to Covered Services include:

- Cosmetic Services;
- Services rendered to improve a condition that falls within the normal range of such conditions;
- Orthodontia;
- Services to treat tooth decay, periodontal conditions and deficiencies in dental hygiene;
- Removal of impacted teeth;
- The making or repairing of dentures;
- Orthognathic surgery to shorten or lengthen the upper or lower jaw, unless related to a traumatic injury or to a neoplastic or degenerative disease; and
- Services to treat temporomandibular joint syndrome, except as specified in section 6.2.1.
6.2.1 Temporomandibular Joint (TMJ) Services

Benefits are provided for TMJ Services from a Participating Provider as shown in the Benefit Summary. Covered Services include:

1. A diagnostic examination including a history, physical examination and range of motion measurements, as necessary;
2. Diagnostic X-rays;
3. Physical therapy of necessary frequency and duration;
4. Therapeutic injections;
5. Therapy utilizing an appliance/splint which does not permanently alter tooth position, jaw position or bite. Benefits for this therapy will be based on the use of a single appliance/splint, regardless of the number of appliances/splints used in treatment. Coverage of the appliance/splint is under the provisions of this section and coverage is not applicable under section 5.8.2 (Medical Appliances). The benefit for the appliance splint therapy will include an allowance for diagnostic Services, office visits and adjustments; and

TMJ Services are covered as shown in your Benefit Summary; limits may apply.

Covered Services for TMJ conditions do not include dental or orthodontia Services.

6.2.2 Outpatient Hospitalization and Anesthesia for Dental Services

Benefits for outpatient hospitalization and anesthesia for dental Services are covered as those Services listed in the Benefit Summary based upon the type of Services received and will only be provided for Members with complicating medical conditions. Examples of these conditions include, but are not limited to:

- Developmental disabilities;
- Physical disabilities; or
- A combination of medical conditions or disabilities which cannot be managed safely and efficiently in a dental office.

Dental Services are excluded.

6.3 TOBACCO USE CESSATION SERVICES

Coverage is provided for Members 15 years of age and older for participation in a PHP-approved, physician-recommended tobacco use cessation program that follows the United States Public Health Service guidelines. “Tobacco use cessation program” includes educational and medical treatment components, such as but not limited to counseling, classes, nicotine replacement therapy and prescription drugs designed to assist Members in ceasing the use of tobacco products. A list of PHP-approved programs is available online at www.providence.org/healthplans and by calling Customer Service at 503-574-7500 or 800-878-4445.
7. EXCLUSIONS

In addition to those Services listed as not covered in sections 5 and 6, the following are specifically excluded from coverage under this Personal Option Plan.

IMPORTANT NOTE: These exclusions are specific to your Personal Option Benefit Summary. Your Employer may have purchased a Supplemental Benefit offering some of the services excluded below. If this is the case, a separate Benefit Summary for each of your Supplemental Benefits will be included in your Member materials. See section 15 for more information regarding Supplemental Benefits.

General Exclusions:
We do not cover Services and supplies which:

- Are not provided;
- Are provided without charge or for which you would not be required to pay if you did not have this coverage;
- Are received before the Effective Date of Coverage;
- Are not a Covered Service or relate to complications resulting from a Non-Covered Service, except for Services provided as Emergency Care as described in section 5.5;
- Are not furnished by a Qualified Practitioner or Qualified Treatment Facility;
- Are provided by or payable under any plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law;
- Are provided while you are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies, except to the extent provided by 38 U. S. C. § 1729 as it relates to non-military Services provided at a Veterans Administration Hospital or facility;
- Are provided while you are in the custody of any law enforcement authorities or while incarcerated;
- Are self-administered or provided by a person who ordinarily resides in your home or who is a member of your immediate family (parent, spouse, sibling or child);
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos and books, educational programs to which drivers are referred by the judicial system and volunteer mutual support groups;
- Are performed in association with a Service that is not covered under this Personal Option Plan;
- Are provided for any injury or illness that is sustained by an Eligible Employee or a Family Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers’ Compensation Act or similar law is required for the Eligible Employee or Family Member. This exclusion also applies to injuries and illnesses that are the subject of a disputed claim settlement under a Workers’ Compensation Act or similar law. This exclusion does not apply to Members who are exempt under any Workers’ Compensation Act or similar law;
- Are payable under any automobile medical, personal injury protection, automobile no-fault, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance makes benefits or Services available to you, whether or not you make application for such benefits or Services. Any benefits or Services provided under this Personal Option Plan that are subject to this exclusion are provided solely to assist you and such assistance does not waive our right to reimbursement or subrogation as specified in section 8.4. This exclusion also applies to Services and supplies after you have received proceeds from a settlement as specified in section 8.4.3;
- Are provided in an institution that specializes in treatment of developmental disabilities;
- Are provided for treatment or testing required by a third party or court of law which is not Medically Necessary;
- Are Experimental/Investigational;
- Are determined by us not to be Medically Necessary for diagnosis and treatment of an injury or illness;
- Are received by a Member under the Oregon Death with Dignity Act;
• Relate to any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member, if such Member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, “illegal” means any engagement or act that would constitute a felony or misdemeanor punishable by up to a year’s imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or mental health condition); and

• Relate to a civil revolution, riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.

We do not cover:

• Charges that are in excess of UCR costs;
• Custodial Care;
• Transplants, except as provided in section 6.1;
• Services for Durable Medical Equipment (DME), Medical Supplies/Devices and Prosthetic Devices except as described in section 5.8;
• Charges for Services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to, air conditioners, air purifiers, vacuum cleaners, motorized transportation equipment, escalators, elevators, tanning beds, ramps, waterbeds, hypoallergenic mattresses, cervical pillows, swimming pools, whirlpools, spas, exercise equipment, gravity lumbar reduction chairs, home blood pressure kits, personal computers and related equipment or other similar items or equipment;
• Physical therapy and rehabilitation Services, except as provided in sections 5.4.3 and 5.9.3;
• “Telephone visits” by a physician or “environment intervention” or “consultation” by telephone for which a charge is made to the patient. “Get acquainted” visits without physical assessment or diagnostic or therapeutic intervention provided and online treatment sessions;
• Missed appointments;
• Non-emergency medical transportation;
• Allergy shots and allergy serums, except as provided in section 5.9.4;
• All Services and supplies related to the treatment of obesity or morbid obesity, except as provided in section 5.9.11;
• Services for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas, except as provided in section 5.9.11;
• Transportation or travel time, food, lodging accommodations and communication expenses except as provided in section 6.1 and with our prior approval;
• Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
• Massage therapy;
• Light therapy for seasonal affective disorder, including equipment;
• Any vitamins, dietary supplements, and other non-prescription supplements;
• Services for genetic testing are excluded, except for Services to establish a diagnosis of a suspected congenital condition. Genetic testing is not covered for screening, to diagnose carrier states, or for informational purposes in the absence of disease;
• Services to modify the use of tobacco and nicotine, except when provided in section 6.3 and as Extra Values and Discounts, where available;
• Cosmetic Services including supplies and drugs, except as approved by us and provided in sections 5 and 6;
• Services, including routine physical examination, immunizations and vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel;
• Non-sterile examination gloves;
• Sales taxes, handling fees and similar surcharges, as explained in the definition of UCR; and
• Air ambulance transportation for non-emergency situations unless approved by us in advance.

Exclusions that apply to Mental Health and Chemical Dependency Services:
• Conditions for mental and nervous conditions that are specified as excluded in section 16, Definitions, for Mental Health and Chemical Dependency;
• Services provided under a court order or as a condition of parole or probation or instead of incarceration which are not Medically Necessary;
• Personal growth Services such as assertiveness training or consciousness raising;
• Services related to developmental disabilities, developmental delays or learning disabilities including, but not limited to, education Services. A learning disability is a condition where there is meaningful difference between a child’s current academic function and the level expected for a child that age. Educational Services include, but are not limited to, language and speech training, reading, and psychological and visual integration training as defined by the American Academy of Pediatrics Policy Statement - “Learning Disabilities, Dyslexia and Vision: A Subject Review”;
• School counseling and support Services, home-based behavioral management, household management training, peer support Services, recreation, tutor and mentor Services; independent living Services, therapeutic foster care, wraparound Services; emergency aid for household items and expenses; Services to improve economic stability, and interpretation Services;
• Evaluation or treatment for education, professional training, employment investigations, and fitness for duty evaluations;
• Community Care Facilities that provide 24-hour non-medical residential care;
• Speech therapy, physical therapy and occupational therapy Services provided in connection with treatment of psychosocial speech delay, learning disorders, including mental retardation and motor skill disorders, and educational speech delay including delayed language development (except as provided in sections 5.4.3. and 5.9.3);
• Counseling related to family, marriage, sex and career including, but not limited to, counseling for adoption, custody, family planning or pregnancy, in the absence of a DSM-IV-TR diagnosis;
• Neurological Services and tests including, but not limited to EEGs; PET, CT and MRI imaging Services, and beam scans (except as provided in section 5.9.8);
• Services related to the treatment of sexual disorders, dysfunctions or addiction;
• Vocational, pastoral or spiritual counseling;
• Dance, poetry, music or art therapy, except as part of an approved treatment program;
• Treatments that do not meet the national standards for Mental Health/Chemical Dependency professional practice; and
• For Members of Small Group Plans, as stated in your Benefit Summary, residential Mental Health Services or Chemical Dependency Services in excess of 60 days per calendar year.

Exclusions that apply to Provider Services:
• Services that are provided, ordered or approved by Non-Participating Providers, except as otherwise stated in this Personal Option Plan;
• Services of licensed acupuncturists, a physician performing acupuncture Services, naturopathic physicians, chiropractic physicians and licensed massage therapists; and
• Services of homeopaths; faith healers; or lay, Direct Entry or Certified Professional midwives.
Exclusions that apply to Reproductive Services:

- All Services related to sexual disorders or dysfunctions regardless of gender or cause, including all Services related to a sex-change operation, including evaluation, surgery and follow-up Services;
- All Services for the treatment of infertility, including all Services related to surrogate parenting. For the purpose of this exclusion, infertility is defined as the inability to become pregnant after a year of unprotected intercourse or the inability to carry a pregnancy to term as evidenced by three consecutive spontaneous abortions;
- Termination of pregnancy, unless there is a severe threat to the mother, or if the life of the fetus cannot be sustained;
- Sterilization (tubal ligation and vasectomy) Services;
- Reversal of voluntary sterilization;
- Condoms and other over-the-counter birth control products; and
- Services provided in a premenstrual syndrome clinic or holistic medicine clinic.

Exclusions that apply to Vision Services:

- Surgical procedures which alter the refractive character of the eye, including, but not limited to laser eye surgery, radial keratotomy, myopic keratomileusis and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia, hyperopia or astigmatism;
- Services for routine eye care and vision care, vision exams/screenings, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in sections 5.2.5, 5.5.3 and 5.8.2 and as covered under a vision Endorsement, if any, to this Personal Option Plan; and
- Orthoptics and vision training.

Exclusions that apply to Hearing Services:

- Hearing aids, hearing therapies and/or devices, including all Services related to the examination and fitting of the hearing aids, except as provided in sections 5.8.5 and 5.10.4; and
- Hearing screenings and exams, except as provided in section 5.10.1.

Exclusions that apply to Dental Services:

- Oral surgery (non-dental or dental) or other dental Services (all procedures involving the teeth; wisdom teeth; areas surrounding the teeth; dental implants), except as approved by us and described in section 6.2;
- Services for temporomandibular joint syndrome (TMJ) and orthognathic surgery, except as approved by us and described in section 6.2.1; and
- Dentures and orthodontia.

Exclusions that apply to Foot Care Services:

- Routine foot care, such as removal of corns and calluses, except for Members with diabetes; and
- Services for orthotics, insoles, arch supports, heel wedges, lifts and orthopedic shoes, except as provided in section 5.8.2 (Medical Appliances).

Exclusions that apply to Prescription Drugs, Medicines and Devices:

- Outpatient prescription drugs, medicines and devices except as provided in section 5.9.2, or as covered under an Endorsement to this Personal Option Plan; and
- Any drug, medicine, or device that does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Pre-market Approval, or 510K.
8. CLAIMS ADMINISTRATION

This section explains how we treat various matters having to do with administering your benefits and/or claims, including situations that may arise in which your health care expenses are the responsibility of a source other than us.

8.1 CLAIMS PAYMENT

Our payments for most Services are made directly to the providers of Services. Except as otherwise specifically provided in this Personal Option Plan, if you are billed directly and pay for benefits which are covered by this Personal Option Plan, reimbursement from us will be made only upon your written notice to us of the payment. Payment will be made to the Subscriber, subject to written notice of claim, or, if deceased, to the Subscriber’s estate, unless payment to other parties is authorized in writing by you.

Explanation of Benefits (EOB)

You will receive an EOB from Providence Health Plan after we have processed your claim. An EOB is not a bill. An EOB explains how Providence Health Plan processed your claim, and will assist you in paying the appropriate member responsibility to your provider. Copayment or Coinsurance amounts, services or amounts not covered and general information about our processing of your claim are explained on an EOB.

Time Frames for Processing Claims

If Providence Health Plan denies your claim we will send an EOB to you with an explanation of the denial within 30 days after we receive your claim. If we need additional time to process your claim for reasons beyond our control, we will send a notice of delay to you explaining those reasons within 30 days after we receive your claim. We will then complete our processing and send an EOB to you within 45 days after we receive your claim. If we need additional information from you to complete our processing of your claim, we will send you a separate request for information and you will have 45 days to submit the additional information. Once we receive the additional information from you we will complete our processing of the claim within 30 days.

8.1.1 Timely Submission of Claims

We will make no payments for claims received more than 365 days after the date of Service. Exceptions may be made if we receive documentation that you lacked legal capacity during that period. Payment of claims submitted by the Oregon state Medicaid agency or a prepaid managed care health services organization described in ORS 414.725 will be made in accordance with ORS 743.847.

Payment of all claims will be made within the time limits required by OAR 836-080-0235. Please send all claims to:

Providence Health Plan
Attn: Claims Dept.
P.O. Box 3125
Portland, OR 97208-3125

8.1.2 Right of Recovery

We have the right, upon demand, to recover from a recipient the value of any benefit or claim payment that exceeded the benefits available under this Personal Option Plan. Our right of recovery applies to any excess benefit, including (but not limited to) benefits obtained through fraud, error, or duplicate coverage relating to any Member. If timely repayment is not made, we have the right, in addition to any other lawful means of recovery, to deduct the value of the excess benefit from any future benefit that otherwise would have been available to the affected Member(s) from us under any contract.
8.2 COORDINATION OF THIS PERSONAL OPTION PLAN’S BENEFITS WITH OTHER BENEFITS

This Coordination of Benefits (COB) section applies when a Member has health care coverage under more than one Plan. The term “Plan” is defined below for the purposes of this COB section. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

8.2.1 Definitions Relating to Coordination of Benefits

**Plan**

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

1. Plan includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare Supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage listed under (1) or (2) above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

**This Plan**

This Plan means, as used in this COB section, the part of this contract to which this COB section applies and which may be reduced because of the benefits of other plans. Any other part of this contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules listed in section 8.2.2 determine whether This Plan is a Primary plan or Secondary plan when a Member has health care coverage under more than one Plan.

When This Plan is primary, we determine payment for our benefits first before those of any other Plan without considering any other Plan’s benefits. When This Plan is secondary, we determine our benefits after those of another Plan and may reduce the benefits we pay so that all Plan benefits do not exceed 100% of the total Allowable expense.
**Allowable expense**

Allowable expense means a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering a Member. When a Plan provides benefits in the form of Services, the reasonable cash value of each Service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering a Member is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable expense.

The following are examples of expenses that are NOT Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

2. If you are covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

3. If you are covered by two or more Plans that provide benefits or Services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

4. If you are covered by one Plan that calculates its benefits or Services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or Services on the basis of negotiated fees, the Primary plan’s payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or Service for a specific negotiated fee or payment amount that is different than the Primary plan’s payment arrangement and if the provider’s contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

5. The amount of any benefit reduction by the Primary plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

**Closed panel plan**

A Closed panel plan is a Plan that provides health care benefits to Members primarily in the form of Services through a panel of providers that has contracted with or is employed by the Plan, and that excludes coverage for Services provided by other providers, except in cases of emergency or referral by a panel member.

**Custodial parent**

A Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the Dependent child resides more than one half of the calendar year excluding any temporary visitation.
8.2.2 Order of Benefit Determination Rules

When a Member is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan.

B. 
   1. Except as provided in Paragraph (2) below, a Plan that does not contain a COB provision that is consistent with the State of Oregon’s COB regulations is always primary unless the provisions of both Plans state that the complying plan is primary.
   2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

   1. Non-Dependent or Dependent. The Plan that covers a Member other than as a Dependent, for example, as an employee, Subscriber or retiree is the Primary plan and the Plan that covers the Member as a Dependent is the Secondary plan. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Member as a Dependent; and primary to the Plan covering the Member as other than a Dependent (e.g., a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Member as an employee, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

   2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Member is a Dependent child and is covered by more than one Plan the order of benefits is determined as follows:

      a) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
         i. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
         ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

      b) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
         i. If a court decree states that one of the parents is responsible for the Dependent child’s health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
ii. If a court decree states that both parents are responsible for the Dependent child’s health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

iv. If there is no court decree allocating responsibility for the Dependent child’s health care expenses or health care coverage, the order of benefits for the Dependent child are as follows:

- The Plan covering the Custodial parent, first;
- The Plan covering the spouse of the Custodial parent, second;
- The Plan covering the non-custodial parent, third; and then
- The Plan covering the Dependent spouse of the non-custodial parent, last.

c) For a Dependent child covered under more than one Plan of individuals who are not the parents of the Dependent child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the Dependent child.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a Member as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same Member as a retired or laid-off employee is the Secondary plan. The same would hold true if a Member is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a Member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the Member as an employee, subscriber or retiree or covering the Member as a Dependent of an employee, Subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the Member the longer period of time is the Primary plan and the Plan that covered the Member the shorter period of time is the Secondary plan.

6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than we would have paid had we been the Primary plan.
8.2.3 Effect on the Benefits of This Plan
When This Plan is secondary, we may reduce our benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

If a Member is enrolled in two or more Closed panel plans and if, for any reason, including the provision of Services by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

8.2.4 Right to Receive and Release Needed Information
Certain facts about health care coverage and Services are needed to apply this COB section and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying this section and determining benefits payable under This Plan and other Plans covering a Member claiming benefits. We need not tell, or get the consent of, any person to do this. Each Member claiming benefits under This Plan must give us any facts we need to apply this section and determine benefits payable.

8.2.5 Facility of Payment
A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term “payment made” includes providing benefits in the form of Services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of Services.

8.2.6 Right of Recovery
If the amount of the payments made by us is more than we should have paid under this COB section, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or Services provided for the Member. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of Services.

8.3 NON–DUPlication OF COVERAGE

8.3.1 Coordination with Medicare
In all cases, coordination of benefits with Medicare will conform with federal statutes and regulations. Medicare means Title XVIII of the Social Security Act, as enacted or amended. Medicare eligibility and how we determine our benefit limits are affected by disability and employment status. Please contact Customer Service if you have questions.

In accordance with the “working aged” provisions of the Medicare Secondary Payer Manual, when the Employer Group’s size is less than 20 employees, Medicare will be assumed to be the primary payer and we will coordinate benefits as the secondary payer even if the Medicare-eligible Member has not elected coverage under Medicare.
When the Employer Group’s size is 20 individuals or more, Medicare will be considered the secondary payer.

Counting individuals for the Employer size:

- Employees counted in the Employer size include the total number of nationwide full-time employees, part-time employees, seasonal employees, and partners who work or who are expected to report for work on a particular day.
- Those not counted in the Employer size include retirees, COBRA-qualified beneficiaries and individuals on other continuation options, and self-employed individuals who participate in the Employer’s group health plan.

8.4 THIRD-PARTY LIABILITY/SUBROGATION

The following provisions will apply when you or any other Member has received Services for a condition for which one or more third parties may be responsible. “Third party” means any person other than the Member (the first party to this contract), and Providence Health Plan (the second party), and includes any insurance carrier providing liability or other coverage potentially available to the Member. For example, uninsured or underinsured motorist coverage, no-fault medical payments (auto, homeowners or otherwise), or other group insurance (including student plans) whether under the Member’s policy or not, are subject to recovery by us as a third-party recovery. Failure by the Member to comply with the terms of this section will be a basis for us to deny any claims for benefits arising from the condition or to terminate the Member’s coverage under this Personal Option Plan as specified in section 10.3. In addition, you or the Member must execute and deliver to us and to other parties any document requested by us which may be appropriate to confirm or secure the rights and obligations of the Member and Providence Health Plan under these provisions.

8.4.1 Third-Party Liability/Subrogation and How it Affects You

Third-party liability refers to claims that are in whole or part the responsibility of someone besides Providence Health Plan or the Member. Examples of third-party liability are motor vehicle accidents, workplace injury or illness, and any other situation involving injury or illness, including wrongful death, in which the Member or the Member’s heirs, beneficiaries or relatives have a basis to bring a lawsuit or to make a claim for compensation against any person or for which the Member or the Member’s heirs, beneficiaries or relatives may receive a settlement. Once it has been established that the third party is responsible to pay and is capable of paying for the expenses for the Services caused by that third party, we will not provide benefits for the Services arising from the condition caused by that third party. Such benefits are specifically excluded from coverage under this Personal Option Plan.

If we make claim payments on any Member’s behalf for any condition for which a third party is responsible, we are entitled to be repaid promptly for those payments, directly out of any recovery from the third party, including any settlement, award, verdict, payment or other monetary recovery.

“Subrogation” means that we may collect directly from the third party to the extent we have paid for third-party liabilities. Because we have paid for the Member’s injuries, we, rather than the Member, are entitled to recover those expenses. Prior to accepting any settlement of the Member’s claim against a third party, the Member must notify us in writing of any terms or conditions offered in settlement and must notify the third party of our interest in the settlement established by this provision.
To the maximum extent permitted by law, we are subrogated to the Member’s rights against any third party who is responsible for the condition, have the right to sue any such third party in the Member’s name, and have a security interest in and lien upon any recovery to the extent of the amount of benefits paid by us and for our expenses in obtaining a recovery. If the Member should either decline to pursue a claim against a third party that we believe is warranted or refuse to cooperate with us in any third party claim that the Member does pursue, we have the right to pursue such claim directly, including commencing a legal action against such third party or intervening in any action that the Member may have commenced.

To accomplish this process, we need detailed information from you or from the Member. A questionnaire will be sent to the Member for this information. It should be completed and returned to our office as soon as possible to minimize any claim review delay. If you or the Member has any questions or concerns regarding the questionnaire, please contact our office. A Providence Health Plan employee who specializes in third-party liability/subrogation can discuss our procedures and what you or the Member needs to do.

8.4.2 Proceeds of Settlement or Recovery

If for any reason we are not paid directly by the third party, we are entitled to reimbursement from the Member or the Member’s heirs, legal representatives, beneficiaries or relatives, and we may request refunds from the medical providers who treated the Member, in which case those providers will bill the Member for their Services. To the fullest extent permitted by law, we are entitled to the proceeds of any settlement, award, verdict, or other payment that results in a monetary recovery from a third party, whether or not responsibility is accepted or denied by the third party for the condition, whether or not such monetary recovery is described by any person as something other than a recovery of medical expenses incurred by us, and whether or not the Member is alleged to have any fault, under principles of comparative negligence or otherwise. With respect to any workers’ compensation recovery, we are entitled to the proceeds whether or not the loss is deemed to be compensable under the workers’ compensation laws. We are entitled to recover up to the full value of the benefits provided by us for the condition, calculated using our UCR charges for such Services, less our pro-rata share of the Member's out-of-pocket expenses and attorney fees incurred in making the recovery. We are entitled to such recovery regardless of whether the Member has been fully compensated or “made whole” for the loss caused by the third party, and regardless of whether the Member has been partially compensated for such loss. We are entitled to first priority in repayment, over the Member and over any other person, for such charges.

By accepting benefits under this Personal Option Plan, the Member acknowledges our first priority to this repayment and assign to us any benefits the Member may have from other sources. The Member must cooperate fully with us in recovering amounts paid by us. If any Member seeks damages against the third party for the condition and retains an attorney or other agent for representation in the matter, that Member agrees to require the Member’s attorney or agent to reimburse us directly from the settlement or recovery in the amount provided by this section.

The Member must complete our trust agreement, by which the Member and any Member’s attorney (or other agent) must confirm the obligation to reimburse us directly from any settlement or recovery. We may withhold benefits for the Member’s condition until a signed copy of this agreement is delivered to us. The agreement must remain in effect and we may withhold payment of benefits if, at any time, the Member’s confirmation of the obligations under this section should be revoked. While this document is not necessary for us to exercise our rights under this section, it serves as a reminder to the Member and directly obligates any Member’s attorney to act in accord with our rights.
8.4.3 Suspension of Benefits and Reimbursement

After the Member has received proceeds of a settlement or recovery from the third party, the Member is responsible for payment of all medical expenses for the continuing treatment of the illness or injury that Providence Health Plan would otherwise be required to pay under this Personal Option Plan until all proceeds from the settlement or recovery have been exhausted. If the Member has failed to reimburse us as required by this section, we are entitled to offset future benefits otherwise payable under this Personal Option Plan, or under any future plan with us, to the extent of the value of the benefits advanced under this section.

If the Member continues to receive medical treatment for the condition after obtaining a settlement or recovery from one or more third parties, we are not required to provide coverage for continuing treatment until the Member proves to our satisfaction that the total cost of the treatment is more than the amount received in settlement or recovered from the third party, after deducting the cost of obtaining the settlement or recovery. We will only cover the amount by which the total cost of benefits that would otherwise be covered under this Personal Option Plan, calculated using our UCR charges for such Services, exceeds the amount received in settlement or recovery from the third party. We are entitled to suspend such benefits even if the total amount of such settlement or recovery does not fully compensate the Member for other damages, particularly including lost wages or pain and suffering.

Any settlement arising out of an injury or illness covered by this Personal Option Plan will be deemed first to compensate you for your medical expenses, regardless of any allocation of proceeds in any settlement document that we have not approved in advance. In no event shall the amount reimbursed to us be less than the maximum permitted by law.
9. PROBLEM RESOLUTION

9.1 INFORMAL PROBLEM RESOLUTION

All of the employees of Providence Health Plan share responsibility for assuring Member satisfaction. If you have a problem or concern about your coverage, including benefits or Services by Participating Providers or payment for Services by Non-Participating Providers, please ask for our help. Your Customer Service representatives are available to provide information and assistance. You may call us or meet with us at the phone number and address listed on your Member ID Card. If you have special needs, such as a hearing impairment, we will make efforts to accommodate your requirements. Please contact us so we may help you with whatever special needs you may have.

9.2 MEMBER GRIEVANCE AND APPEAL

9.2.1 Your Grievance and Appeal Rights

If you disagree with our decision about your medical bills or health care services you have the right to two levels of internal review. You may request review if you believe that we have not paid a bill correctly, will not approve care you believe should be covered, or are stopping care you believe you still need. You may also file a quality of care or general complaint with us. Please include as much information as possible including the date of the incident, the names of individuals involved, and the specific circumstances. In filing a Grievance or appeal:

- You can submit written comments, documents, records and other information relating to your Grievance or appeal and we will consider that information in our review process.
- You can, upon request and free of charge, have reasonable access to and copies of the documents and records held by us that relate to your Grievance or appeal.

Filing a Grievance or appeal does not affect your right to receive benefits for Covered Services as otherwise provided under this Plan. To the extent possible, complaints filed by telephone will be resolved at the point of service by a Customer Service representative. All Grievances and appeals (except those involving Prior Authorizations, as noted below) will be acknowledged within seven days of receipt by us and resolved within 30 days, or sooner depending on the clinical urgency. We may request an additional 15 days to resolve the issue if we provide you with a notice of delay, including the reason for the delay, before the 30-day period has elapsed.

Urgent Medical Conditions: If you believe your health would be seriously harmed by waiting for our decision on your Grievance or appeal of a denied Prior Authorization request, you may request an expedited review by calling a Customer Service representative at 503-574-7500 or 800-878-4445 outside of the Portland area. If your appeal is urgent and qualifies for external review, you may request to have both your internal and external appeal expedited at the same time. We will let you know by phone and letter if your case qualifies for an expedited review. If it does, we will notify you of our decision within 72 hours of receiving your request.

Grievances and Appeals Involving Prior Authorizations (Non-Urgent): If your Grievance or appeal involves a Prior Authorization request for a non-urgent medical condition, we will notify you of our decision, (a) Within 15 days of receiving your request for a first level Grievance or appeal or, (b) Within 15 days of receiving your request for a second level appeal.

Grievances and Appeals Involving Concurrent Care Decisions: If we have approved an ongoing course of treatment for you and determine through our medical management procedures to reduce or terminate that course of treatment, we will provide advance notice to you of that decision. You may request reconsideration of our decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. We will then notify you of our reconsideration decision within 24 hours of receiving your request.
9.2.2 First Level Grievance or Appeal
You must file your first level Grievance or appeal within 180 days of the date on our notice of the initial determination, or that initial determination will become final. Please advise us of any additional information that you want considered in the review process. If you are seeing a non-participating provider, you should contact that provider's office and arrange for the necessary records to be forwarded to us for the review process. Your Grievance or appeal will be reviewed by Providence Health Plan staff not involved in the initial determination. You may present your case in writing. Once a final determination is made you will be sent a written explanation of the decision.

9.2.3 Second Level Appeal
If you are not satisfied with our decision on the first level Grievance or appeal, you may request a second level appeal and our Grievance Committee will review your case. The Grievance Committee is made up of individuals not involved in the initial Grievance or appeal, and consists of Providence Health Plan staff and one or more community representatives. You must submit your written request for the Grievance Committee review within 60 days of the date on the first level Grievance or appeal decision notice, or that first level decision will become final. You may present your case to the Grievance Committee in writing, by telephone conference call, or in person at our Beaverton, Ore., location. The Grievance Committee will review the documentation presented by you and send a written explanation of its decision.

9.2.4 External Review
If you are not satisfied with the decision of the Grievance Committee and your appeal involves a denial of services because they are not medically necessary, not an active course of treatment for purposes of continuity of care, because they are experimental/investigational, or whether a course of treatment is delivered in an appropriate setting at an appropriate level of care, you may request an external review by an Independent Review Organization (IRO). Your request must be made in writing within 180 days of receipt of the Grievance Committee’s final review decision, or that internal decision will become final. If you agree, we may waive the requirement that you exhaust the internal review process before beginning the External Review process. When the external review process is begun, an IRO will be assigned to the case by the Oregon Insurance Division and we will forward complete documentation regarding the case to the IRO. The IRO is entirely independent of Providence Health Plan and performs its review under a contract with the Oregon Insurance Division. The IRO will notify you and us of its decision. We agree to be bound by and to comply with the IRO decision when the decision involves, (a) medically necessary treatment, (b) experimental/investigational treatment, (c) an active course of treatment for purposes of continuity of care, or (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care.

All costs for the handling of external review cases are paid by us and we administer these provisions in accordance with the insurance laws and regulations of the State of Oregon. By electing to submit your appeal to an IRO, you are also agreeing to be bound by and to comply with the IRO decision regarding your appeal in lieu of appealing to a state or federal court. If we do not comply with the IRO decision, you have the right to sue us under applicable Oregon law.
9.2.5 How to Submit Grievances or Appeals
To submit your Grievance or appeal, or to request our annual report on Grievances and internal appeals, you may contact a Customer Service representative at 503-574-7500 or 800-878-4445. If you are hearing impaired and use a Teletype (TTY) Device, please call our TTY line at 503-574-8702 or 888-244-6642. Written Grievances or appeals should be sent to:

Providence Health Plan
Appeals and Grievance Department
P.O. Box 4327
Portland, OR 97208-4327

You may fax your Grievance or appeal to 503-574-8757 or 800-396-4778, or you may hand deliver it (if mailing, use only the post office box address listed above) to the following address:

Providence Health Plan
3601 SW Murray Blvd., Ste. 10
Beaverton, OR 97005

9.2.6 Assistance Outside of Providence Health Plan
You may, at any time during the Grievance and appeal process, seek assistance from the Oregon Insurance Division with your concerns regarding our decisions and benefits. You may contact the Oregon Insurance Division at the following address:

Oregon Insurance Division
Consumer Protection Unit
350 Winter Street NE, Room 440
Salem, OR 97301-3883

503-947-7984 (phone) or 888-877-4894 (toll-free)
503-378-4351 (fax)
dcbs.insmail@state.or.us (email)
http://egov.oregon.gov/DCBS/insurance.shtml (internet)
10. TERMINATION OF MEMBER COVERAGE

Termination of Member coverage under this Personal Option Plan will occur on the earliest of the following dates:

1. The date this Personal Option Plan terminates;
2. The end of the period for which required Premium was due to us and not received by us;
3. The date stated in the Employer/Group Agreement when a Subscriber terminates employment with the Employer;
4. The date stated in the Employer/Group Agreement when a Subscriber no longer qualifies as a Subscriber;
5. The date stated in the Employer/Group Agreement when a Subscriber fails to pay required Premiums by the end of the grace period;
6. The date stated in the Employer/Group Agreement when a Member is no longer in an eligible class of persons as provided in the Description of Classes as shown in the Employer/Group Agreement;
7. The date stated in the Employer/Group Agreement when a Member enters full-time military, naval or air service, except as provided under federal USERRA requirements or similar state laws;
8. The date stated in the Employer/Group Agreement when a Subscriberretires;
9. The last day of the month in which the Subscriber makes a written request for termination of coverage to be effective for the Subscriber or Member;
10. For a Family Member, the date the Subscriber's coverage terminates;
11. For a Family Member, the last day of the month in which the individual no longer qualifies as an Eligible Family Dependent;
12. For any benefit, the date the benefit is deleted from this Personal Option Plan;
13. For a Member, the date of disenrollment from this Personal Option Plan as described in section 10.3;
14. For a Member, the date any fraudulent information is provided; or
15. For a Member, the date we discover any breach of contractual duties, conditions or warranties, as determined by us.

You and the Employer are responsible for advising us of any changes in eligibility including the lack of eligibility of a Family Member. Coverage will not continue beyond the last date of eligibility, regardless of the lack of notice to us.

10.1 RESCISSION OF COVERAGE

Your coverage under this Plan may not be rescinded except for fraud or intentional misrepresentation of material fact.
10.2 **NON-LIABILITY AFTER TERMINATION**

Upon termination of this Personal Option Plan, we shall have no further liability beyond the effective date of the termination unless the Member continues, without lapse of membership, under another Providence Health Plan plan.

If the Employer has immediately replaced this Personal Option Plan with another group policy and a Member is hospitalized when this Personal Option Plan terminates, he or she shall continue to receive benefits for Covered Services until discharged from the Hospital or until the limits of coverage under this Personal Option Plan have been reached, whichever is earlier.

We will provide information to the Employer so the Employer can inform the Members of the termination of this Personal Option Plan. It will be the Employer’s responsibility to inform all Members that this Personal Option Plan has terminated.

10.3 **DISENROLLMENT FROM THIS PERSONAL OPTION PLAN**

“Disenrollment” means that your coverage under this Personal Option Plan is terminated by us because you have engaged in fraudulent, dishonest or threatening behavior with regard to us, such as:

1. You have filed a false claim with us;
2. You willfully fail to provide information or documentation required to be provided under this Personal Option Plan or knowingly provide incorrect or incomplete information;
3. You have committed an act of physical or verbal abuse that poses a threat to providers, to other Members, or to Providence Health Plan employees; or
4. You have allowed a non-Member to use your Member ID Card to obtain Services.

10.4 **NOTICE OF CREDITABLE COVERAGE**

We will provide written certification of the Member’s period of Creditable Coverage when:

- A Member ceases to be covered under this Personal Option Plan;
- A Member on COBRA coverage ceases that coverage; and
- A Member requests a Notice of Creditable Coverage within 24 months of the termination of coverage.

10.5 **EMPLOYER’S RIGHT TO TERMINATE OR AMEND PLAN**

Your Employer reserves the right at any time to terminate or amend in whole or part any of the provisions of the Plan or any of the benefits provided under the Plan. Any such termination or amendment may take effect retroactively or otherwise. In the event of a termination or reduction of benefits under the Plan, the Plan will be liable only for benefit payments due and owing as of the effective date of such termination or reduction and no payments scheduled to be made on or after such effective date will result in any liability to the plan or your Employer.
11. CONTINUATION OF GROUP MEDICAL BENEFITS

If you become ineligible for coverage under this Personal Option Plan you may, under certain circumstances, continue group coverage. There are specific requirements, time frames and conditions that must be followed in order to be eligible for continuation of group coverage and which are generally outlined below. Please contact your Employer as soon as possible for details if you think you may qualify for group COBRA or state continuation coverage. Also see Portability Plans in section 12 for individual coverage. Portability coverage may be available before, during or at the end of group COBRA or state continuation coverage.

11.1 STATE-MANDATED CONTINUATION COVERAGE

11.1.1 Groups with 20 or More Employees

STATE-MANDATED CONTINUATION COVERAGE

If a surviving, divorced or legally separated spouse of the Subscriber is at least 55 years old at the time of death or the dissolution or legal separation of the marriage; she or he may be eligible to continue coverage.

This state-mandated continuation of coverage will terminate upon the earliest of any of the following:
1. The failure to pay Premiums when due, including any grace period;
2. The date that the Personal Option Plan is terminated;
3. The date on which the surviving, divorced or legally separated spouse becomes insured under any other group health plan;
4. The date on which the surviving, divorced or legally separated spouse remarries and becomes covered under another group health plan; or
5. The date on which the surviving, divorced or legally separated spouse becomes eligible for federal Medicare coverage.

The covered Dependent children of the spouse also remain eligible for coverage with the spouse as long as they remain otherwise eligible under the terms of the Personal Option Plan.

11.1.2 Groups Not Subject to COBRA (Groups with 19 or less Employees, and Groups with 20 or more Employees that are otherwise exempt from COBRA)

State-mandated continuation of coverage is available to you if you have been covered continuously under this Personal Option Plan, or a similar predecessor group health plan, during the three month period on the date of termination of employment or membership.

You may be eligible for continuation of coverage if:
1. Your coverage ends because of the termination of employment of the Subscriber; or
2. Your coverage ends because the Subscriber’s reduction in work hours; or
3. Your coverage ends because of the death of the spouse, the dissolution of the marriage, or a legal separation; or
4. In the case of Dependent children, when your children no longer meet Eligible Family Dependent requirements.

IMPORTANT: You must request state continuation coverage in writing to us within 31 days after the date on which your coverage under this Personal Option Plan would otherwise end. You are responsible for making the full monthly premium payment in advance to the Employer each month.
11.1.3 Maximum Length of Coverage
State continuation of group coverage terminates the earlier of:

1. Nine months after the date on which the Subscriber’s coverage under this Personal Option Plan otherwise would have ended because of termination of employment or membership.
2. Nine months after the start of a leave of absence from which a Subscriber does not return to work.
3. Nonpayment: The end of the month for which you last made timely payment 30 days from the date the Premium is due.
4. Medicare: The first of the month in which you become entitled to Medicare benefits.
5. Other Group Coverage: The date you become eligible under another group health plan as a covered employee or as a Dependent. If your new plan has a Pre-existing Condition clause, Services that would be denied as a Pre-existing Condition under your new plan will be covered by us until the end of the pre-existing waiting period. Your coverage under this Personal Option Plan will terminate at the end of the new plan’s pre-existing waiting period.
6. Remarriage: The date the former spouse remarries and, because of the remarriage, becomes covered under another group health plan.

11.2 COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that applies to most Employers with 20 or more employees. Some Employers, such as church groups and state agencies, may be exempt from COBRA. The law requires that Employers subject to COBRA offer Employees and/or their Dependents continuation of medical and dental coverage in certain instances where there is a loss of group coverage.

11.2.1 Subscriber’s Continuation Coverage
A Subscriber who is covered under this Personal Option Plan may elect continuation coverage under COBRA if coverage is lost due to termination of employment (other than for gross misconduct) or a reduction in work hours.

11.2.2 Spouse’s or Domestic Partner’s Continuation Coverage
A spouse or domestic partner who is covered under this Personal Option Plan has the right to elect continuation coverage under COBRA if coverage is lost for any of the following qualifying events:

- The death of the Subscriber;
- The termination of the Subscriber’s employment (for reasons other than gross misconduct) or reduction in hours;
- The divorce or legal separation of the Subscriber and the spouse;
- Termination of the domestic partnership; or
- The Subscriber becomes covered under Medicare.
11.2.3 Dependent’s Continuation Coverage
A dependent child who is covered under this Personal Option Plan has the right to continuation under COBRA if coverage is lost for any of the following qualifying events:

- The death of the Subscriber;
- The termination of the Subscriber’s employment (other than for gross misconduct) or reduction in a Subscriber’s hours;
- The Subscriber’s divorce or legal separation;
- Termination of the domestic partnership;
- The Subscriber becomes covered under Medicare; or
- The child ceases to qualify as an Eligible Family Member under this Personal Option Plan.

A newborn child or a child placed for adoption who is properly enrolled under the terms of this Personal Option Plan during the COBRA continuation period will be a qualified beneficiary.

11.2.4 Notice Requirements
A Family Member’s coverage ends on the last day of the month in which a divorce, legal separation or termination of domestic partnership occurs or a child loses dependent status under this Personal Option Plan. Under COBRA, you or your Family Member has the responsibility to notify your Employer if one of these events occurs. Written notice must be given no later than 60 days after the loss of coverage has occurred, or the qualifying event, whichever is later. Oral notice is not binding until confirmed in writing. If notice is not timely given, continuation coverage will not be available.

When your Employer receives notification of one of the above “qualifying” events, you will be notified that you or your Family Member, as applicable, have 60 days from the date coverage is lost or the date you receive the notice, whichever is later, to elect continuation coverage. If this election is not made within this 60-day period, your right to elect continuation coverage under this Personal Option Plan will be lost.

11.2.5 Type of COBRA Continuation Coverage
A qualified beneficiary will be provided the same coverage that was in effect immediately prior to the qualifying event.

11.2.6 COBRA Election Rights
A Subscriber or his or her spouse or domestic partner may elect continuation coverage for all covered Family Members. In addition, each Family Member has an independent right to elect COBRA. Thus, a Family Member may elect continuation coverage even if the Subscriber does not.

11.2.7 COBRA Premiums
If you are eligible for COBRA continuation coverage, you do not have to show that you are insurable (that you do not have any serious health conditions). However, you must pay the full premium for your continuation coverage, including the portion of the premium your Employer was previously paying, to your Employer. After you elect COBRA, you will have 45 days from the date of election to pay the first premium. You must pay premium back to the point you would otherwise have lost coverage under this Personal Option Plan. After that, you must pay the premium for each month as of the first of the month, and in all events within 30 days. If you fail to pay your monthly premium, you will be notified that your coverage is being terminated.
11.2.8 Length of COBRA Continuation Coverage

18-Month Continuation Period
When coverage ends due to a Subscriber’s termination of employment (other than for gross misconduct) or a reduction in hours, the continuation period for the Subscriber and all covered Family Members will be 18 months from the date of the qualifying event, or the date coverage is lost, whichever is later.

29-Month Continuation Period
If a qualified beneficiary is disabled, continuation coverage for that qualified beneficiary and his or her covered Family Members may continue for up to 29 months from the date of the original qualifying event, or loss of coverage, whichever is later. The 29-month period applies only if the following conditions are met:

- The Social Security Administration (SSA) determines that the qualified beneficiary is disabled at any time prior to the qualifying event or during the first 60 days of COBRA continuation coverage; and
- The qualified beneficiary provides the Employer with a copy of the SSA determination within the initial 18-month continuation period and not later than 60 days after the SSA determination was issued.

The premium for COBRA continuation coverage may increase after the 18th month to 150% of the otherwise applicable amount.

If the SSA makes a final determination of non-disability, the qualified beneficiary must notify the COBRA Administrator within 30 days.

36-Month Continuation Period
If a spouse, domestic partner or dependent child loses coverage because of any of the following reasons, COBRA provides for up to 36 months of continuation of coverage:

- The Subscriber’s death;
- The Subscriber's eligibility for Medicare;
- Divorce or legal separation;
- Termination of the domestic partnership; or
- A child becomes ineligible for dependent coverage.

11.2.9 Extension of Continuation Period
If a second qualifying event occurs during the initial 18- or 29-month continuation period (for example, the death of the employee, divorce, or child loses status as an Eligible Family Member under the Plan), coverage for a qualified beneficiary may be extended up to 36 months. However, in no case will the continuation coverage exceed 36 months from the date of the original qualifying event.

If a spouse or dependent child has continuation coverage due to the employee’s termination or reduction in hours and if the qualifying event occurred within 18 months after the employee became entitled to Medicare, the coverage period is extended to 36 months from the employee’s Medicare entitlement date.

11.2.10 Other Information
Please contact your Employer for any questions regarding COBRA continuation. Notify your Employer of any changes in marital status, or a change of address.

THIS CONTINUATION OF COVERAGE EXPLANATION IS NOT INTENDED TO SATISFY THE EMPLOYER’S LEGAL REQUIREMENTS OF NOTICE AS OUTLINED IN THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA).
11.3 CONTINUATION OF BENEFITS DURING LABOR STRIKE

If Premiums are paid by your Employer under the terms of a collective bargaining agreement and there is a cessation of work by the employees due to a strike or lockout, this Personal Option Plan will continue in effect if the Subscribers continue to pay the Premium due. The union, which represents the Subscribers, shall be responsible for collecting and paying the Premium by the due date. The amount payable by each Subscriber shall be the Premium for the category in which the Subscriber belongs plus a maximum of 20% increase to pay the increased cost by us. Nothing in this paragraph shall be deemed to limit any right we may have in accordance with the terms of this Personal Option Plan to increase or decrease the Premium.

Coverage under this paragraph shall continue until the first of the following occurs:

1. Less than 75% of Subscribers, at the time of cessation of work, continue coverage;
2. Six months after cessation of work; or
3. For an individual Subscriber and Eligible Family Dependents, the time at which the Subscriber takes full-time employment with another Employer.

11.4 CONTINUATION OF BENEFITS AFTER INJURY OR ILLNESS COVERED BY WORKERS’ COMPENSATION INSURANCE

Coverage under this Personal Option Plan shall be available to Subscribers who are not actively working and have filed a Workers’ Compensation insurance claim. Premium contribution amounts/levels will be the same as if the Subscriber was actively at work and such Premium payments may be the responsibility of the Subscriber, in accordance with the policies of the Employer. This continuation of benefits is administered in accordance with the coverage extensions provision and with any state or federal continuation requirements. The Subscriber may maintain such coverage until the earlier of:

1. The Subscriber takes full-time employment with another Employer; or
2. Six months from the date that the payment of Premium is made under this provision.

11.5 COVERAGE EXTENSIONS

Coverage extension refers to the extension of full coverage for the Subscriber and any Family Members during which the Employer agrees to pay any portion of the cost of coverage under the terms of any collective bargaining agreements, policy, other agreements or Personal Option Plan provisions. A coverage extension follows an event that meets the requirements of a Qualifying Event under federal COBRA regulations. During an Extension Period the Subscriber and any Family Members shall be considered to be COBRA Members and the Extension Period shall be counted toward the Member’s maximum entitlement period for COBRA continuation coverage.
12. INDIVIDUAL PORTABILITY PLANS

12.1 ELIGIBILITY

If your medical coverage under this Personal Option Plan terminates, a choice of two individual Portability Plans is available to provide uninterrupted coverage. To be eligible for coverage, you must meet the following requirements:

1. You must have been covered under one or more Oregon group Health Benefit Plans for at least 180 days;
2. You must apply for Portability coverage not later than the 63rd day after termination of your group coverage; and
3. You must reside in Oregon.

You are NOT eligible for coverage under a Portability Plan if:

1. You are eligible for federal Medicare coverage;
2. You remain eligible for your prior active group coverage;
3. You are covered, or would be covered at the time Portability coverage would otherwise begin, under another group plan, policy, contract, or agreement providing benefits for Hospital or medical care; or
4. You move out of Oregon. (Please contact Customer Service at the number listed on your Member ID Card for additional information.)

Only persons covered under this group Personal Option Plan on the date coverage terminates are eligible to be covered under an individual Portability Plan.

The Portability Plan may be issued covering each former Member on a separate basis or it may be issued covering all former Members together. However, if termination of coverage under this Personal Option Plan is due to dissolution of marriage by annulment or final divorce decree, only those persons who cease to be Eligible Family Dependents of the Subscriber are eligible for Portability Plan contract.

This privilege does NOT apply when your Employer’s participation in this Personal Option Plan terminates and medical coverage is replaced within 31 days by another group insurance plan.

12.2 PORTABILITY PLANS

You will have a choice of two Portability Plans, the Prevailing Benefit Plan or the Low Cost Benefit Plan, after the termination of your group coverage.

The Portability Plan is a new contract and not a continuation of your terminated group coverage. The Portability Plan’s benefits and premiums will differ from those provided under your group coverage. The benefits that may be available to you will be described in a Benefit Summary provided to you when you request an application for a Portability Plan from us. Contact Customer Service at the number listed on your Member ID Card for additional information regarding the cost and benefits of the Portability Plans.

Please Note: In accordance with state mandated benefit provisions for Portability coverage, there is a 24-month Exclusion Period for coverage of human organ/tissue transplants. The Exclusion Period can be reduced or eliminated, however, by the application of Creditable Coverage.
12.3 EFFECTIVE DATE AND PREMIUM

After you lose eligibility for coverage under this group Personal Option Plan, you may apply for a Portability Plan before, during or at the end of any COBRA or state continuation coverage. You have 63 days after the date your group coverage terminates to apply and pay the required Premium for your individual Portability Plan. The Premium must be paid in advance. You may obtain application forms from us. The Portability Plan will be effective on the day after your group medical coverage ends, if you enroll and pay the first Premium within 63 days after the date your coverage ends.

The Premium for the Portability Plan will be the Premium charged by us as of the effective date based upon the Portability Plan, classification of risk, age and benefit amounts selected. The Premium may change as provided in the Portability Plan contract.
13. MEMBER RIGHTS AND RESPONSIBILITIES

13.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES

As a Member of Providence Health Plan, you should know what to expect from us, as well as what we ask from you. Nobody knows more about your health than you and your doctor. We take responsibility for providing the very best health care services and benefits possible; your responsibility is to know how to use them well. Please take time to read and understand your benefits. We want you to have a positive experience with Providence Health Plan, and we are ready to help in any way.

Members have the right to:

- Be cared for by people who respect your privacy and dignity.
- Be informed about Providence Health Plan, our providers, and the benefits and Services you have available to you as a Member.
- Receive information that helps you select a Participating Provider or Qualified Practitioner whom you trust and with whom you feel comfortable.
- A candid discussion of appropriate or Medically Necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Receive information and clinical guidelines from your health care provider or your health plan that will enable you to make thoughtful decisions about your health care.
- Actively participate in decisions that relate to your health and your medical care through discussions with your health care provider or through written advance directives.
- Have access to medical Services that are appropriate for your needs.
- Express a concern and receive a timely response from Providence Health Plan.
- Have your claims paid accurately and promptly.
- Request a review of any service not approved, and to receive prompt information regarding the outcome.
- Make recommendations regarding the member rights and responsibilities policy.
- Refuse care from specific providers.

Members have the responsibility to:

- Read and understand the information in and the terms of your Personal Option Plan. We will have no liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this plan. If you have any questions or are unclear about any provision concerning this plan, please contact us. We will assist you in understanding and complying with the terms of the plan.
- Talk openly with your physician or provider and work toward a relationship built on mutual trust and cooperation.
- Follow the treatment plan that you and your Qualified Practitioner have agreed upon.
- Provide to the extent possible medical information your physicians or providers request from you.
- Do your part to prevent disease and injury. Try to make positive, healthful choices. If you do become ill or injured, seek appropriate medical care promptly.
- Treat your physicians or providers courteously.
- Make your required Copayment at the time of Service.
- Show your member ID card whenever you receive medical Services.
- Let us know if you have concerns or if you feel that any of your rights are being compromised, so that we can act on your behalf.
- Call or write within 180 days of service if you wish to request a review of Services provided or appeal a Providence Health Plan decision.
- Notify Customer Service if your address changes.
**Providence Health Plan has the responsibility to:**

- Respect and honor your rights.
- Ensure timely access to appropriate health care Services.
- Enable you to see physicians or providers who meet your needs.
- Develop a variety of benefits to serve you well.
- Assure the ongoing quality of our providers and services.
- Contract with providers who are capable, competent, and committed to excellence.
- Make it easy and convenient for you to appeal any policy or decision that you believe prevents you from receiving appropriate care.
- Provide you with accurate up-to-date information about Providence Health Plan and Participating Providers.
- Provide you with information and services designed to help you maintain good health and receive the greatest benefit from the services we offer.
- Ensure privacy and confidentiality of your medical records with access according to law.
- Ensure that your interests are well represented in decisions about Providence Health Plan policy and governance.
- Encourage physicians and providers to make medical decisions that are always in your best interest.

13.2 **ERISA INFORMATION FOR MEMBERS (PARTICIPANTS)**

The following information applies to Members (participants) who are covered by a plan that is subject to the federal ERISA (Employee Retirement Income Security Act of 1974) requirements for employee benefit plans. Typically, all Employer-sponsored plans except those sponsored by a state or local government entity or a church organization are subject to ERISA.

As a participant in your Employer’s Group Plan, you are entitled to certain rights and protections under ERISA, which provides that all Plan participants are entitled to:

- **Receive information about your Employer’s group plan and benefits from the Plan administrator (your Employer)**
  - Examine, without charge, at your Employer’s offices, and at other specified locations, such as worksites, all plan documents, including insurance contracts and, if applicable, a copy of the latest annual report (Form 5500) filed by your Employer with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
  - Obtain, upon written request to your Employer, copies of documents governing the operation of the plan, including insurance contracts, the updated summary plan description and, if applicable, the latest annual report (Form 5500). Your Employer or its plan administrator may make a reasonable charge for the copies.
  - Receive a summary of the annual financial report for your Employer’s group plan. Your Employer or its plan administrator is required by law to prepare and furnish each participant with this Summary Annual Report (SAR), but only if the plan covers 100 or more participants.

- **Continue group health plan coverage**
  - Continue health care coverage for yourself, spouse or dependents under the circumstances described in section 11.2 if, (a) there is a loss of coverage under the plan as a result of a qualifying event and, (b) your Employer has 20 or more employees. You or your Dependents may have to pay for such coverage. *(Please refer to section 11.2 for more information about COBRA.)*
• Receive a reduction or elimination of exclusionary periods of coverage for Pre-existing conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, when you lose coverage under your Employer’s group plan, when you become entitled to elect COBRA continuation coverage (if applicable), when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date. (Please refer to the Certificate of Creditable Coverage information in section 10.4 and the Pre-existing Condition Exclusion information in section 4.11).

• Prudent actions by plan fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of your Employer’s group plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and the other plan participants and beneficiaries. No one, including your Employer, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

• Enforce your rights
If your claim for a plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report (Form 5500) from your Employer or their plan administrator and you do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require your Employer or their plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond their control.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with a decision, or lack thereof, by your Employer or their plan administrator concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that the fiduciaries of the plan misuse the plan’s money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim to be frivolous).

• Assistance with your questions
If you have any questions about your plan, you should contact your Employer or their plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from your Employer or their plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.
13.3 NON-ERISA INFORMATION FOR MEMBERS (PARTICIPANTS)

The following information applies to Members (participants) who are covered by a plan that is not subject to ERISA.

As a participant in your Employer’s Group Plan, you are entitled to certain rights and protections under Oregon law, which provides that all Plan participants are entitled to:

1. Receive from us information maintained about you by your Employer’s group plan
   - You are entitled within 30 days to access to recorded personal information under ORS 746.640, provided you request it in writing and reasonably describe the information.
   - You may obtain copies, subject to paying a reasonable copying charge.
   - You are entitled to know to whom we may have disclosed any such information.
   - You are entitled to correct any errors in the information.

2. Continue group health coverage
   - Continue health care coverage for yourself, spouse or dependents under the circumstances described in section 11.1.

3. Enforce your rights

   If your claim for a plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

   As more fully described in section 9, we offer a Grievance process that attempts to resolve the concerns Members may have about claims decisions. No civil action may be brought to recover benefits from this Group Contract until receipt of a final decision under the Member Grievance and Appeal process specified in section 9.2 of this Group Contract. If the Member elects to seek external review under section 9.2.5, both we and the Member will be bound by the IRO decision. No civil action may be brought later than three years after the date of the last decision rendered under the Member Grievance and Appeal process specified in section 9.2.

   Member’s sole right of appeal from a final Grievance determination, other than a determination referred for binding determination by an independent review organization, shall be to binding arbitration before a single arbitrator appointed by the United States Arbitration & Mediation Service (USA&M), and any action brought to determine benefits from this Group Contract shall be referred to USA&M for arbitration in accordance with USA&M’s Rules for Arbitration. The arbitrator’s decision shall be final and legally binding and judgment may be entered thereon.
14. GENERAL PROVISIONS

14.1 AMENDMENT OF THE GROUP CONTRACT
The provisions of the Group Contract may be amended, subject to receiving any required regulatory approval(s), by agreement between the Employer and us. Any such amendment shall become effective on the date specified in the amendment. The payment of Premium for any period of coverage after the effective date of an amendment shall constitute the acceptance of the amendment by the Employer if we have provided written notice of the amendment to the Employer prior to the payment of such Premium.

14.2 AVAILABILITY OF CONTRACT
The Employer shall maintain a copy of the Group Contract in a location and under circumstances in which it will be available for your reference. Additionally, we will provide access to a copy of the Group Contract to any Member upon request.

14.3 BINDING EFFECT
The Group Contract shall be binding upon and inure to the benefit of the heirs, legal representatives, successors and assigns of the parties hereto.

14.4 CIRCUMSTANCES BEYOND THE CONTROL OF PROVIDENCE HEALTH PLAN
If a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within our control results in the facilities, personnel, or financial resources of Providence Health Plan being unavailable to provide, or make arrangements for basic or supplemental health service, then we are required only to make a good-faith effort to provide, or make arrangements for the Service, taking into account the impact of the event. For this purpose, an event is not within the control of Providence Health Plan if we cannot exercise influence or dominion over its occurrence.

14.5 CHOICE OF STATE LAW
The laws of the State of Oregon govern the interpretation of this Group Contract and the administration of benefits to Members, except as provided in the Employer Group Agreement. Oregon law will govern the interpretation of any requirements applicable to Members who are out-of-area or who reside out of the Service Area.

14.6 DUPLICATING PROVISIONS
If any charge is described as covered under two or more benefit provisions, we will pay only under the provision allowing the greater benefit. This may require us to make a recalculation based upon both the amounts already paid and the amounts due to be paid. We have NO liability for benefits other than those this Group Contract provides.

14.7 FAILURE TO PROVIDE INFORMATION OR PROVIDING INCORRECT OR INCOMPLETE INFORMATION
Employers and Members warrant that all information contained in applications, questionnaires, forms, or statements submitted to us to be true, correct, and complete. If a Member or Employer willfully fails to provide information required to be provided under the Group Contract or knowingly provides incorrect or incomplete information, then the Member or Employer’s rights may be terminated. See section 10.3 and the Employer Group Agreement.

In addition, if an Employer fails to furnish information as required to be furnished under terms of the Group Contract, the Employer will indemnify, defend, save and hold harmless Providence Health Plan from any lawsuits, demands, claims, damages or other losses arising from the Employer’s failure to inform us or Members of such required information.
In the absence of fraud, all statements made by applicants, the Employer or Members shall be deemed representations and not warranties, and no statement made for the purpose of effecting coverage under the Group Contract shall avoid the Group Contract or reduce benefits unless contained in a written instrument signed by the Employer or the Member, a copy of which has been furnished to the Employer or to the Member.

14.8 **HOLD HARMLESS**

The Employer acknowledges that Providence Health Plan and its Participating Providers have entered into contracts requiring that in the event Providence Health Plan fails to pay for Services that are covered under this Group Contract that the Participating Providers shall not bill or otherwise attempt to collect from Members for any amounts owed to them under this Group Contract by Providence Health Plan, and Members shall not be liable to Participating Providers for any such sums. The Employer further acknowledges that the hold harmless agreements described in this section do not prohibit Participating Providers from billing or collecting any amounts that are payable by Members under this Group Contract, such as Copayment, Coinsurance and Deductible amounts.

14.9 **INTEGRATION**

The Group Contract and any attached amendments, embodies the entire contract of the parties. There are no promises, terms, conditions or obligations other than those contained herein. The Group Contract shall supersede all other communications, representations or agreements, either verbal or written, between the parties.

14.10 **LEGAL ACTION**

No civil action may be brought under state or federal law to recover benefits from the Group Contract until receipt of a final decision under the Member Grievance and Appeal process specified in section 9.2 of the Group Contract, unless the Member’s benefits under the Group Contract are subject to the Employee Retirement Income Security Act (ERISA), in which case the Member may bring a civil action under ERISA in federal court after receiving a decision from the First Level of Appeal. No civil action under ERISA or otherwise may be brought later than three years after the date of the last decision rendered under the Member Grievance and Appeal process specified in section 9.2.

14.11 **NON-TRANSFERABILITY OF BENEFITS**

No person other than a Member is entitled to receive benefits under the Group Contract. Such right to benefits is nontransferable.

14.12 **NONWAIVER**

No delay or failure when exercising or enforcing any right under the Group Contract shall constitute a waiver or relinquishment of that right and no waiver or any default under this contract shall constitute or operate as a waiver of any subsequent default. No waiver of any provision of the Group Contract shall be deemed to have been made unless and until such waiver has been reduced to writing and signed by the party waiving the provision.

14.13 **NO RECOUPSE FOR ACTS OF PROVIDERS**

The Hospitals, Skilled Nursing Facilities, physicians and other persons or organizations providing Services to you do so as independent contractors. We are not liable for any claim or demand due to damages arising out of or in any manner connected with any injuries suffered by you while receiving such Services.
14.14 **NOTICE**

Any notice required of us under the Group Contract shall be deemed to be sufficient if mailed to the Subscriber at the address appearing in the records of Providence Health Plan. Any notice required of the Employer or you shall be deemed sufficient if mailed to the principal office of Providence Health Plan, P.O. Box 3125 Portland, OR 97208.

14.15 **PHYSICAL EXAMINATION AND AUTOPSY**

We, at our own expense, shall have the right and opportunity to examine any Member when and as often as it may reasonably require during the pendency of any claim covered by the Group Contract. We also have the right to make an autopsy in case of death if not forbidden by law.

14.16 **PROFESSIONAL REVIEW AND RIGHT TO EXAMINE RECORDS**

All Members, by acceptance of the benefits of the Group Contract, shall be deemed to have consented to the examination of medical records for purposes of utilization review, quality assurance and peer review by Providence Health Plan or our designee.

All Members, for purposes other than utilization review, quality assurance and peer review, may be required to authorize any provider to give and discuss with us any information relating to any condition for which benefits are claimed under the Group Contract. We may transfer this information between providers or other organizations who are treating you or performing a Service on our behalf. If you do not consent to the release of records or to discussions with providers, we will be unable to determine the proper payment of any benefits and will deny the claims accordingly. Consent to the release of records and discussion with providers is a condition of payment of any benefits. Neither the consent to, nor the actual examination of the records or discussion with providers will constitute a guarantee of payment.

14.17 **PRORATION OF BENEFITS**

Benefits are based on a calendar year. If the benefits under the Group Contract are modified, or if you change to another Group Contract within Providence Health Plan, the benefit limits shall be prorated accordingly.

14.18 **SEVERABILITY**

Invalidation of any term or provision herein by judgment or court order shall not affect any other provisions, which shall remain in full force and effect.

14.19 **SUGGESTIONS**

You are encouraged to make suggestions to us. Suggestions may be oral or written and should be directed to the Customer Service Team at our administrative office.

14.20 **WORKERS' COMPENSATION INSURANCE**

This group contract is not in lieu of, and does not affect, any requirement for coverage under any workers’ compensation act or similar law.
15. SUPPLEMENTAL BENEFITS

This section provides additional information about the Supplemental Benefits that may be included with your Plan. Not all plans include Supplemental Benefits.

What are Supplemental Benefits? Supplemental Benefits are any benefits purchased by your Employer in addition to your Providence Health Plan health care coverage. Examples are: prescription drug, alternative care, chiropractic care, vision and elective sterilization Services.

Do I have Supplemental Benefits? If your Plan includes coverage for Supplemental Benefits, your Member materials will include a Benefit Summary for each Supplemental Benefit.

15.1 PRESCRIPTION DRUG SUPPLEMENTAL BENEFIT

The Prescription Drug Supplemental Benefit provides coverage for prescription drugs which are Medically Necessary for the treatment of a covered illness or injury and which are dispensed by a participating pharmacy pursuant to a prescription ordered by a Qualified Practitioner for use on an outpatient basis, subject to your Plan’s benefits, limitations and exclusions.

Prescription Drug Definition
The following are considered “prescription drugs”:
1. Any medicinal substance which bears the legend, “Caution: federal law prohibits dispensing without a prescription”;
2. Insulin;
3. Any medicinal substance of which at least one ingredient is a federal or state legend drug in a therapeutic amount; and
4. Any medicinal substance which has been approved by the Oregon Health Resources Commission as effective for the treatment of a particular indication.

15.1.1 Using Your Prescription Drug Benefit

Your prescription drug benefit requires that you fill your prescriptions at a participating pharmacy. You have broad access to over 22,000 participating pharmacies and their services at discounted rates. Providence Health Plan participating pharmacies are those pharmacies that maintain all applicable certifications and licenses necessary under state and federal law of the United States and have an agreement with us to provide prescription drug benefits pursuant to this Supplemental Benefit.

Pharmacies are designated as participating retail, preferred retail, specialty and mail-order pharmacies. To view a list of our participating pharmacies visit our website at www.providence.org/healthplans. You also may contact Customer Service at the telephone number listed on your Member ID Card.

- Please present your Member ID Card to the participating pharmacy at the time you request services. If you have misplaced or do not have your Member ID Card with you, please ask your pharmacist to call us.
- All covered Services are subject to the Deductible, Copayments or Coinsurance and benefit maximums listed on your Prescription Drug Benefit Summary.
- Copayments, Coinsurance and any difference in cost for prescription drug Covered Services do not apply to your medical Calendar Year Deductibles or medical Out-of-Pocket Maximums.
- Participating pharmacies may not charge you more than your Copayment or Coinsurance. Please contact Customer Service if you are asked to pay more or if you or the pharmacy have questions about your prescription drug benefits or need assistance processing your prescription.
- Copayments or Coinsurance are due at the time of purchase.
• You may purchase up to a 90-day supply of each maintenance drugs at one time using a participating mail-service or preferred retail pharmacy. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies. To purchase prescriptions by mail, your physician or provider can call in the prescription or you can mail your prescription along with your Providence Health Plan Member ID number to one of our participating mail-order pharmacies. To find our participating mail-order pharmacies please visit our website at www.providence.org/healthplans. (Not all prescription drugs are available through our mail-order pharmacies.)

• Diabetes supplies and inhalation extender devices may be obtained at a participating pharmacy. However, these items are considered medical supplies and devices and are subject to your Personal Option Plan’s medical supplies and devices benefits, limitations and Copayments and/or Coinsurances. See section 5.8 and your Personal Option Benefit Summary.

• Self-administered chemotherapy drugs are covered under your Personal Option plan unless the benefits under this Supplemental Prescription Drug Benefit allow for a lower out-of-pocket cost to you.

• Some prescription drugs require Prior Authorization in order to be covered as listed in our Prescription Drug Formulary.

15.1.2 Use of Non-Participating Pharmacies

On rare occasions, such as urgent or emergency situations, you may need to use a non-participating pharmacy. If this happens, you will need to pay full price for your prescription at the time of purchase.

To request reimbursement, you will need to fill out and submit to us a Prescription Drug Reimbursement form. This form is available on our website or by contacting Customer Service. When you submit the completed Prescription Drug Reimbursement form, include any itemized pharmacy receipts, along with an explanation as to why you used a non-participating pharmacy. Submission of a claim does not guarantee payment.

If your claim is approved, we will reimburse you the cost of your prescription up to our participating pharmacy contracted rates, less your applicable Copayment or Coinsurance. Reimbursement is subject to your Plan’s limitations and exclusions. You are responsible for any amounts above our contracted rates.

15.1.3 Prescription Drug Formulary

Our formulary is a list of Food and Drug Administration (FDA) approved prescription brand-name and generic drugs developed by physicians and pharmacists. It is designed to offer drug treatment choices for covered medical conditions. The formulary can help you and your Physician choose effective medications that are less costly and minimize your out-of-pocket expense. There are effective generic drug choices to treat most medical conditions. The formulary also includes current clinical drug information, therapeutic approach to disease and comparative cost information to be used as a reference by prescribing physicians.

All drugs must be FDA approved, medically necessary, and require by law a prescription to dispense. Not all FDA-approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety and medical necessity within 12 months following FDA approval.

We maintain a closely managed, open formulary. Formulary status is given to drugs that meet evidence-based assessment of therapeutic effectiveness, safety, pharmacoeconomic value and offer an important advantage to existing formulary alternatives.

Newly approved FDA drugs will be reviewed for safety and medical necessity within 12 months following FDA approval by Providence Health Plan's Pharmacy & Therapeutics Committee. In the case of an urgent situation, we will authorize the use of a newly-approved FDA drug during our review period so a Member does not go without Medically Necessary treatment.
Our formulary is updated regularly throughout the year and Qualified Practitioners are encouraged to submit suggestions for additions to us. Specialty medications and medications requiring Prior Authorization are listed in our formulary. You may obtain a copy of the formulary from our website or by contacting Customer Service.

15.1.4 Generic, Brand-Name and Value-Based Prescription Drugs
Both generic and brand-name drugs are covered benefits subject to the terms of your Prescription Drug Benefit Summary. In general, generic drugs are subject to lower Copayments or Coinsurances than brand-name drugs. Please refer to your Prescription Drug Benefit Summary for your Copayment or Coinsurance information.

If you are on a Copayment only prescription drug plan (as opposed to a combined Copayment/Coinsurance prescription drug plan), regardless of the reason or Medical Necessity, and you request a brand-name drug, or if your provider prescribes a brand-name drug when a generic is available, you may be responsible for the difference in cost between the brand-name and generic drug, in addition to your brand-name drug Copayment, as indicated on your Prescription Drug Benefit Summary. Your total cost, however, will never exceed the actual cost of the drug.

If you are on one of our Value-Based prescription drug plans, Value-Based drugs are covered at a lower Copayment as stated in the Value-Based Supplemental Prescription Drug Benefit Summary. Value-Based drugs are commonly used medications for treating chronic conditions such as diabetes, high blood pressure, high cholesterol, heart disease, depression, asthma and other breathing disorders. These medications are on our formulary, may be generic or brand-name and are considered first-line treatments for many conditions.

15.1.5 Prescription Drug Quantity
Prescription dispensing limits, including refills, are as follows:

1. topicals, up to 60 grams;
2. liquids, up to eight ounces;
3. tablets or capsules, up to 100 dosage units; and
4. multi-use or unit-of-use, up to one container or package; as prescribed, not to exceed a 30-consecutive-day supply, whichever is less.

Other dispensing limits may apply to certain medications requiring limited use, as determined by our medical policy. Prior Authorization is required for amounts exceeding any applicable medication dispensing limits.

15.1.6 Participating Mail-Order and Preferred Retail Pharmacies
Up to a 90-day supply of prescribed maintenance drugs (drugs you have been on for at least 30 days and that you anticipate continuing on in the future) purchased from a participating mail-order or preferred retail pharmacy will be covered subject to the following specific provisions:

1. Qualified drugs under this program will be determined by us. Not all prescription drugs are available through mail-order pharmacy.
2. Not all maintenance prescription drugs are available in 90-day allotments.
3. Copayment(s) will be applied to the quantity stated on your medical Benefit Summary. (Some quantity limitations and Copayments for unit of use packaging may apply).

When using a mail-order pharmacy, payment is required prior to processing your order. If there is a change in our participating mail-service or preferred retail pharmacies, you will be notified of the change at least 30 days in advance.
15.1.7 Prescription Drug Out-of-Pocket Maximum
Some Supplemental Prescription Drug Benefits have a prescription drug Out-of-Pocket Maximum. If this applies to your prescription drug coverage, it will be listed on your Prescription Drug Benefit Summary. Once the combined Copayments and/or Coinsurances you pay in a calendar year for covered prescription drugs meets the individual or family prescription drug Out-of-Pocket Maximum, we will pay 100% for covered prescription drugs for the remainder of that calendar year, subject to any benefit maximums. The prescription drug Out-of-Pocket Maximum only applies to your Supplemental Prescription Drug Benefit, and does not apply to your Personal Option Out-of-Pocket Maximum. For Value-Based prescription drug plans, the prescription drug Out-of-Pocket Maximum only applies to non-formulary and compounded prescription drugs.

15.1.8 Prescription Drug Limitations
Prescription drug limitations are as follows:

1. All drugs must be Food and Drug Administration (FDA) approved, medically necessary and require by law a prescription to dispense. Not all FDA-approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety and medical necessity within 12 months following FDA approval.

2. Certain drugs require Prior Authorization for medical necessity, place of therapy, length of therapy, step therapy, number of doses or dispensing limits. Step therapy uses our pharmacy claims history to confirm if certain drugs have been tried first by a Member. If a drug has not been tried first, cannot be tried first, or if the drug history is not available, Prior Authorization is required. For some drugs, we limit the amount of the drug we will cover. Please have your provider contact us directly for Prior Authorization. If you have questions regarding a specific drug, please call Customer Service.

3. Specialty drugs are injectable, infused, oral or inhaled therapies that often require specialized delivery, handling, monitoring and administration and are generally high cost. These drugs must be purchased through our designated specialty pharmacy. Due to the nature of these medications, they are not considered maintenance drugs and are limited to a 30-day supply (or minimum package size to approximate a 30-day supply). Specialty drugs are listed in our formulary. You may obtain a copy of the formulary from our website at www.providence.org/healthplans or by contacting Customer Service.

4. Self-injectable medications are only covered if they are intended for self-administration; labeled by the FDA for self administration; and are referenced in our formulary.

5. Medications, drugs or hormones prescribed to stimulate growth except when there is a laboratory confirmed diagnosis of growth hormone deficiency for children through 18 years of age and when prescribed for the treatment of documented pituitary destruction in adults.

6. Compound prescription drugs must contain at least one ingredient that is an FDA-approved prescription drug in therapeutic amount and must be purchased at a participating pharmacy. Compounded drugs from bulk powders that are not a component of an FDA-approved drug are not covered.
15.1.9 Prescription Drug Exclusions

Prescription drug exclusions are as follows:

1. Drugs or medicines delivered, injected, or administered for you by a physician, other provider or another trained person;

2. Amphetamines and amphetamine derivatives except when used in the treatment of narcolepsy or hyperactivity in children and adults;

3. Drugs used in the treatment of the common cold;

4. Drugs or medications prescribed that do not relate to the treatment of a covered illness or injury;

5. Devices, appliances, supplies and durable medical equipment of any type, even though such devices may require a prescription order. Some of these items may be covered under your medical benefits (see section 5.8);

6. Experimental or investigational drugs or drugs used by a Member in a research study or in another similar investigational environment;

7. Drugs used for the treatment of fertility/infertility;

8. Fluoride, for Members over the age of 10 years old;

9. Drugs that are not provided in accordance with our formulary management program;

10. Drugs used in the treatment of fungal nail conditions;

11. Drugs to stimulate hair growth, including, but not limited to Rogaine (topical minoxidil) or other similar drug preparations;

12. Intrauterine devices (IUDs), diaphragms and other implantable contraceptives. Some of these items may be covered under your medical benefits;

13. Drugs or prescribed medications that are not Medically Necessary or are not provided according to our medical policy;

14. Methadone for the treatment of chemical dependency. However, methadone for pain management is covered (methadone for the treatment of Chemical Dependency may be covered under your Chemical Dependency benefits);

15. Drugs prescribed by naturopathic physicians (N.D.);

16. Over-the-counter (OTC) drugs, medications or vitamins, that may be purchased without a provider’s written prescription and prescription drugs that are available in an OTC therapeutically similar form;

17. Drugs dispensed from pharmacies outside the United States, except when prescribed for urgent/immediate care and emergency medical conditions;

18. Drugs which, by law, do not require a prescription, except insulin;

19. Drugs placed on a prescription-only status as required by state or local law;

20. Replacement of lost or stolen medication;

21. Drugs or medicines used to treat sexual dysfunctions or disorders, in either men or women, such as Viagra or drugs required for, or as a result of, sexual transformation;

22. Drugs used in the treatment of drug-induced fatigue, general fatigue and idiopathic hypersomnia;

23. Smoking cessation drug therapy, including nicotine replacement therapy, except as provided in section 6.3. (Providence Health Plan provides access to discounted smoking cessation programs, including drug therapy.);

24. Drugs dispensed or compounded by a pharmacist that do not have at least one FDA-approved medication in therapeutic amount;
25. Drugs used for weight loss or for cosmetic purposes;
26. Drugs that are not FDA-approved or are designated as “less than effective” by the FDA (also known as “DESI” drugs); and
27. Vaccines, immunizations and preventive medications solely for the purpose of travel.

15.1.10 Prescription Drug Disclaimer
Providence Health Plan is not liable for any claim, injury, demand, or judgment based on tort or other grounds (including, but not limited to, warranty or merchantability) arising out of or in any connection with the sale, compounding, dispensing, manufacturing, or use of any prescription drug covered under this Plan.

15.2 ALTERNATIVE CARE SUPPLEMENTAL BENEFIT

The Alternative Care Supplemental Benefit provides coverage for Services received from Alternative Care Providers for Services that are Medically Necessary and are within the scope of practice of the provider involved in your care.

All Alternative Care benefits are subject to any conditions and benefit limits stated in your Alternative Care Benefit Summary and in this section.

All Alternative Care providers must be licensed in the state in which they practice and must practice within the scope of their license.

15.2.1 Alternative Care Providers
All Members, except Alternative Care Plus* Members, must receive Covered Services from Participating Providers. We have approximately 28,000 alternative care Participating Providers available nationwide. To find an alternative care Participating Provider in your area, visit our website at www.providence.org/healthplans or call Customer Service.

*Alternative Care Plus Members may access Services from any Qualified Alternative Care Provider. Providers must be licensed in the state in which they are practicing, and must practice within the scope of their license. If you have Alternative Care Plus coverage, it will be stated on your Benefit Summary.

You do not need a physician’s referral to see an alternative care provider.

In rare circumstances, our national network may not include a participating alternative care provider in your area. If this happens, please contact our authorizing agent at 800-678-9133 before making an appointment. If our authorizing agent is unable to locate a Participating Provider within a reasonable distance, authorization for use of a Non-Participating Provider will be provided.

All Non-participating Alternative Care Providers must be licensed in the state in which they practice and must practice within the scope of their license.

In some cases, you will need to pay the Non-Participating provider directly for the care you receive, and then submit your itemized billing statement to our authorizing agent for reimbursement. Please submit your claims to:

American Specialty Health Network
777 Front Street
San Diego, CA  92101
Reimbursement for services from Non-Participating Providers is subject to our approval. We will reimburse you the cost of your Services at Usual, Customary and Reasonable rates (UCR), less your applicable Copayment or Coinsurance. You will be responsible for all amounts over the UCR.

*Alternative Care Plus* Members should submit claims directly to Providence Health Plan at:

Providence Health Plan  
Attn: Claims Department  
P.O. Box 3125  
Portland, OR  97208-3125

15.2.2 Acupuncture Care Services  
Covered Services from acupuncturists:
- Office visits.
- Adjunctive therapy which may include acupressure, cupping, moxibustion, or breathing techniques. Adjunctive therapy is only covered when provided during the same course of treatment and in conjunction with acupuncture.
- All adjunctive therapy must be Medically Necessary for the treatment of neuromusculoskeletal disorders, nausea or pain.

The following services are NOT covered from acupuncturists:
- Adjunctive therapy not associated with acupuncture.
- Acupuncture performed with reusable needles.
- Treatment of alcohol, drug or chemical dependency in a specialized inpatient or residential facility.

15.2.3 Chiropractic Care Services  
Covered Services from chiropractors:
- Office visits,
- Manipulation of the spine, joints and/or musculoskeletal soft tissue, a re-evaluation, and/or other Services in various combinations.
- Adjunctive physiotherapy which may include ultrasound, hot packs, cold packs, electrical muscle stimulation or other therapies and procedures which are Medically Necessary for the treatment of neuromusculoskeletal disorders.
- Related diagnostic X-rays and laboratory Services.

The following services are NOT covered from chiropractors:
- Services, exams and/or treatments for conditions other than neuromusculoskeletal disorders.
- All chiropractic appliances or Durable Medical Equipment.
- Adjunctive physiotherapy not associated with chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissues.
- Clinical laboratory studies performed in a chiropractor’s office.
- Venipuncture.
15.2.4 Naturopathic Care Services
Naturopathic physician services are examination, clinical laboratory, diagnostic X-ray, office visit, consultation, and/or adjunctive therapeutic procedures delivered by a naturopathic physician within a course of treatment that both:

a. includes natural treatment methods, modalities, nutritional advice, recommendation of homeopathic protocols, and
b. excludes the prescription of pharmaceuticals (whether prescription or over-the-counter) and surgery or invasive therapeutic procedures.

All naturopathic services must be approved by Providence Health Plan or its authorizing agent as Medically Necessary.

Covered Services from naturopathic physicians:
- Office visits/consultations, therapeutic procedures and other Services provided in various combinations. Office visits must include naturopathic Services.
- Physical therapy which may include ultrasound; hot and cold packs; manual mechanical or electrical stimulation of the muscles; and rehabilitative exercise.
- Non-invasive adjunctive therapy modalities such as diathermy, electrical stimulation, hot and cold packs, hydrotherapy, manipulation massage, range of motion exercises and therapy.
- Related diagnostic X-rays and laboratory Services.

The following services are NOT covered from naturopathic physicians:
- Immunizations, vaccinations, injectables and intravenous infusions (does not include venipuncture for the purpose of obtaining blood samples for laboratory studies).
- Topical and oral drugs, pharmaceuticals, intravenous administered treatments, minor surgery.
- Vaccines/vaccination services, homeopathic products, botanical medicine products.
- Dietary and nutritional supplements, including vitamins, minerals, herbs, herbals and herbal products, injectable supplements and injection services, or other similar products.
- Natural childbirth services.
- The following tests:
  - Comprehensive digestive stool analysis
  - Cytotoxic food allergy test
  - Darkfield examination for toxicity or parasites
  - EAV and electronic tests for diagnosis and allergy
  - Fecal transient and retention time
  - Henshaw test
  - Intestinal permeability
  - Loomis 24-hour urine nutrient/enzyme analysis
  - Melatonin biorhythm challenge
  - Salivary caffeine clearance
  - Sulfate/creatinine ratio
  - Urinary sodium benzoate
  - Urine/saliva pH
  - Tryptophan load test
  - Zinc tolerance test

15.2.5 General Exclusions to Alternative Care Services
The following services are excluded from all alternative care providers:
- Alternative care services not stated as a Covered Service in this section.
- Preventive care services.
- Hypnotherapy, behavior training, sleep therapy and weight programs.
- Education programs, self-care or self-help programs or any self-help physical.
- Training or any related diagnostic testing.
- Massage therapy.
- Thermography.
• Therapeutic modalities and procedures that are considered by us or our authorizing agent to be invasive.
• Emergency care and Urgent/Immediate care services.
• Women’s health care services.
• Transportation costs including local ambulance charges.
• Any service or supply that is not permitted by state law with respect to the alternative care provider’s scope of practice.
• Services in excess of the benefit limits listed in the Alternative Care Supplemental Benefit Summary.
• Services received from Non-Participating Providers, except as discussed in this section (does not apply to Alternative Care Plus).

15.3 **CHIROPRACTIC CARE SUPPLEMENTAL BENEFIT**

The Chiropractic Care Supplemental Benefit provides coverage for Services received from Chiropractic Care Providers provided that the Services are Medically Necessary and are within the scope of practice of the provider involved in your care.

All Chiropractic Care benefits are subject to any conditions and benefit limits stated in your Chiropractic Care Benefit Summary and in this section.

All chiropractors must be licensed in the state in which they practice and must practice within the scope of their license.

15.3.1 **Chiropractic Care Providers**

All Members must receive Covered Services from our nationwide network of participating chiropractors. To find a chiropractic care Participating Provider in your area, visit our website at [www.providence.org/healthplans](http://www.providence.org/healthplans) or call Customer Service.

You do not need a physician’s referral to see a chiropractor.

In rare circumstances, our national network may not include a participating chiropractor in your area. If this happens, please contact our authorizing agent at 800-678-9133 before making an appointment. If our authorizing agent is unable to locate a Participating Provider within a reasonable distance, authorization for use of a Non-Participating Provider will be provided.

All Non-Participating chiropractors must be licensed in the state in which they practice and must practice within the scope of their license.

In some cases, you will need to pay the Non-Participating Provider directly for the care you receive, and then submit your itemized billing statement to our authorizing agent for reimbursement. Please submit your claims to:

American Specialty Health Network
777 Front Street
San Diego, CA  92101

Reimbursement for services from Non-Participating Providers is subject to our approval. We will reimburse you the cost of your services at a Usual, Customary and Reasonable rate, less your applicable Copayment or Coinsurance. You will be responsible for all amounts over the UCR.
15.3.2 Chiropractic Care Services

Covered Services from chiropractors:
- Office visits.
- Manipulation of the spine, joints and/or musculoskeletal soft tissue, a re-evaluation, and/or other Services in various combinations.
- Adjunctive physiotherapy which may include ultrasound, hot packs, cold packs, electrical muscle stimulation or other therapies and procedures which are Medically Necessary for the treatment of neuromusculoskeletal disorders.
- Related diagnostic X-rays and laboratory Services.

The following services are NOT covered from chiropractors:
- Preventive care services.
- Services, exams and/or treatments for conditions other than neuromusculoskeletal disorders.
- All chiropractic appliances or durable medical equipment.
- Adjunctive physiotherapy not associated with chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissues.
- Clinical laboratory studies performed in a chiropractor’s office.
- Venipuncture.
- Services received from a chiropractor that are not listed as a Covered Service.
- Hypnotherapy, behavior training, sleep therapy and weight programs.
- Education programs, self-care or self-help programs or any self-help physical exercise training or any related diagnostic testing.
- Transportation costs including local ambulance charges.
- Massage therapy.
- Thermography.
- Therapeutic modalities and procedures that are considered by us or our authorizing agent to be invasive.
- Emergency care and Urgent/Immediate care services.
- All Women’s health care services.
- Any service or supply that is not permitted by state law with respect to the chiropractor’s scope of practice.
- Services in excess of the benefit limits listed in the Chiropractic Care Supplemental Benefit Summary.
- Services received from Non-Participating Providers, except as discussed in this section.

15.4 VISION CARE SUPPLEMENTAL BENEFIT

The Vision Care Supplemental Benefit provides coverage for routine vision Services.

If your Plan includes coverage for Supplemental Vision Care, your Member materials will include a Vision Care Supplemental Benefit Summary.

All Supplemental Vision Care Benefits are subject to the provisions listed in your Vision Care Supplemental Benefit Summary. Please review this document before accessing vision Services.

Payments for Covered Services provided in excess of the benefit maximums are your responsibility.
Payments for Covered Services provided in excess of the benefit maximums and any Copayments and Coinsurance as stated in your Vision Care Benefit Summary do NOT apply to your medical Out-of-Pocket Maximum.

Covered Services are not subject to the medical Deductible, if any.

COVERED SERVICES

- VISION ANALYSIS
  Covered Services include vision analysis by a licensed Ophthalmologist or an Optometrist. A vision analysis may consist of external and ophthalmoscopic examination, determination of best corrected visual acuity, determination of the refractive state, gross visual fields, basic sensorimotor examination, and glaucoma screening.

- CORRECTIVE EYE WEAR
  Benefits are provided for Covered Services provided by a licensed Optician or Optometrist when prescribed by a licensed Ophthalmologist or Optometrist. Corrective eye wear benefits include lenses, frames and/or contact lenses.

LIMITATIONS AND EXCLUSIONS
In addition to the limitations and exclusions in your Member Handbook, the following services are excluded:

- Orthoptic or vision training;
- Subnormal vision aids, aniseikonic lenses, or Plano (non-prescription lenses) glasses;
- Sun glasses;
- All materials not listed as covered benefits;
- Services and supplies received outside the United States; and
- Services and supplies not specifically provided within this Supplemental Benefit.

If you have questions regarding your Supplemental Vision Care Benefit, please contact Customer Service.

15.5 ELECTIVE STERILIZATION SUPPLEMENTAL BENEFIT

The Elective Sterilization Supplemental Benefit provides coverage for voluntary sterilization (vasectomy or tubal ligation).

If your Plan includes coverage for Supplemental Elective Sterilization, your Member materials will include an Elective Sterilization Supplemental Benefit Summary.

All Supplemental Elective Sterilization Benefits are subject to the provisions listed in your Elective Sterilization Supplemental Benefit Summary. Please review this document before accessing elective sterilization Services.

Please note: Providence Health Plan is a Catholic-sponsored health plan and as a matter of conscience does not offer these Services at Providence Health & Services facilities.

If you have questions regarding your Supplemental Elective Sterilization Benefit, please contact Customer Service.
16. DEFINITIONS

The following are definitions of important capitalized terms used in this Member Handbook.

**Annual**
Annual means once per Calendar Year.

**Benefit Summary**
Benefit Summary means the document with that title which is part of your Personal Option Plan and which summarizes the benefit provisions under your Personal Option Plan.

**Calendar Year**
Calendar Year means a 12-month time period beginning January 1st and ending December 31st.

**Chemical Dependency**
Chemical Dependency means an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual’s social, psychological or physical adjustment to common problems. Chemical Dependency does not mean an addiction to, or dependency on tobacco, tobacco products or foods.

**Coinsurance**
Coinsurance means the dollar amount that you are responsible to pay to a health care provider, after your claim has been processed by us, for a Covered Service that is a percentage of the Usual, Customary and Reasonable charges for the Covered Service, as shown in the medical Benefit Summary.

**Confinement**
Confinement means being a resident patient in a Hospital, Skilled Nursing Facility or Qualified Treatment Facility for at least 15 consecutive hours. Successive Confinements are considered to be one Confinement if:
1. Due to the same injury or illness; and
2. Separated by fewer than 30 consecutive days when you are not confined.

**Contract Year**
Contract Year means a 12-month time period starting from the effective date of the Group Contract.

**Copayment**
Copayment means the dollar amount that you are responsible to pay to a health care provider when you receive certain Covered Services, as shown in the Benefit Summary.

**Cosmetic Services**
Cosmetic Services means Services or surgery performed to reshape structures of the body in order to improve your appearance or self-esteem.

**Covered Service**
Covered Service means a Service that is:
1. Listed as a benefit in the Benefit Summary and in sections 5 and 6;
2. Medically Necessary;
3. Not listed as an exclusion in sections 5, 6 or 7; and
4. Provided to you while you are a Member and eligible for the Service under the Group Contract.
Creditable Coverage
Creditable Coverage means prior health care coverage as defined in 42 U.S.C. § 300gg and includes any coverage remaining in force at the time a Member obtains new coverage. Creditable Coverage includes any group health care coverage (including the Federal Employees Health Benefits Plan and the Peace Corps), individual health care coverage, Medicare, Medicaid, TRICARE, SCHIP, Indian Health Service or tribal organization coverage, state high-risk pool coverage, or a domestic or foreign public health plan.

Custodial Care
Custodial Care means Services that:
1. Do not require the technical skills of a licensed nurse at all times;
2. Include, but are not limited to, assistance with dressing, bathing, eating, ambulation, taking medication and incontinence care; and
3. Are not likely to improve your medical condition.
Such Services will still be considered Custodial Care even if:
1. You are under the care of a physician;
2. The Services are prescribed by a Qualified Practitioner;
3. The Services function to support or maintain your condition; or
4. The Services are being provided by a registered nurse or licensed practical nurse.

Deductible
See section 4.10.1.

Dependent
Dependent means a person who is supported by the Subscriber or the Subscriber’s spouse. See also Eligible Family Dependent.

Director
Director means the Director of the Oregon Department of Consumer and Business Services.

Domestic Partner
A Domestic Partner is:
• At least 18 years of age; and
• Has entered into a Domestic Partnership with a member of the same sex; and
• Has legally registered a Declaration of Domestic Partnership and obtained a Certificate of Registered Domestic Partnership in accordance with Oregon state law.

Note: All provisions of the Group Contract that apply to a spouse shall apply to a Domestic Partner.

Durable Medical Equipment (DME)
Durable Medical Equipment means equipment that must:
1. Be able to withstand repeated use;
2. Be primarily and customarily used to serve a medical purpose; and
3. Not be generally useful to a person except for the treatment of an injury or illness.

Effective Date of Coverage
Effective Date of Coverage means the date upon which coverage under the Group Contract commences for a Member.
Eligibility Waiting Period
Eligibility Waiting Period means the period of employment, as specified in the Employer/Group Agreement, that an otherwise Eligible Employee must complete before coverage will begin under the Group Contract. The Eligibility Waiting Period for a small employer will not exceed 90 days, with coverage effective on the first day of the next month. If an employee enrolls on a special enrollment date, any period before such special enrollment is not an Eligibility Waiting Period.

Eligible Employee
An Eligible Employee is an employee of the Employer who meets the eligibility criteria stated in the Group Contract and Employer/Group Agreement.

Eligible Family Dependent
Eligible Family Dependent means:

1. The legally recognized spouse or Domestic Partner of a Subscriber;
2. In relation to a Subscriber, the following individuals:
   a) A biological child, step-child, or legally adopted child;
   b) An unmarried grandchild for whom the Subscriber or the Subscriber’s spouse provides at least 50% support;
   c) A child placed for adoption with the Subscriber or Subscriber’s spouse;
   d) An unmarried individual for whom the Subscriber or the Subscriber's spouse is a legal guardian and for whom the Subscriber or the Subscriber’s spouse provides at least 50% support; and
   e) A child for whom the Subscriber or the Subscriber’s spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law.

Placement for adoption means the assumption and retention by a Subscriber or a Subscriber’s spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption). Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.

The limiting age for each Dependent child is 26 as stated in the Employer/Group Agreement and such children shall become ineligible for coverage on the last day of the month in which their 26th birthday occurs.

3. An individual specified in subsection 2(a) or 2(d) of this definition if:
   a) The individual is older than the limiting age specified in the Employer/Group Agreement; and
   b) The individual became developmentally or physically disabled and incapable of self-sustaining employment prior to the limiting age.

Proof of incapacity must be provided to us upon enrollment. For Eligible Family Dependents who become incapacitated while covered under the Group Contract, proof of incapacity must be provided within 60 days of reaching the Dependent child limiting age as stated in the Employer/Group Agreement. Thereafter, we may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to us, the individual’s coverage will not continue beyond the last date of eligibility.

Emergency Medical Condition
See section 5.5.1.

Emergency Medical Screening Exams
See section 5.5.1.
**Emergency Services**
See section 5.5.1.

**Employer**
Employer means a Small or Large Employer that is the sponsor of the Group Contract, or any related entity, as described in the Employer/Group Agreement. To be covered under the Group Contract, an individual Employer must meet the definition of Eligible Employee.

**Employer/Group Agreement**
Employer/Group Agreement means the document with that title which is part of the Group Contract and which specifies the eligibility and coverage provisions under the Group Contract.

**Endorsement**
Endorsement means a document that amends and is part of the Group Contract. Endorsements, if any, are identified in the Employer/Group Agreement.

**E-visit**
E-visit (electronic provider communications) means a consultation through email with a Participating Provider that is, in the judgment of the Participating Provider, Medically Necessary and appropriate and involves a significant amount of the Participating Provider’s time. An E-visit must relate to the treatment of a covered illness or injury (see also section 5.1.2).

**Exclusion Period**
Exclusion Period means a period of time during which specified treatments or Services are excluded from coverage, unless such exclusion is modified or eliminated by the application of Creditable Coverage under the Group Contract.

**Experimental/Investigational**
Experimental/Investigational means those Services that are determined by us not to be Medically Necessary or accepted medical practice in the Service Area, including Services performed for research purposes. In determining whether Services are Experimental/Investigational, we will consider whether the Services are in general use in the medical community in the U.S.; whether the Services are under continued scientific testing and research; whether the Services show a demonstrable benefit for a particular illness or disease; whether they are proven to be safe and efficacious; and whether they are approved for use by appropriate governmental agencies. We determine on a case-by-case basis whether the requested Services will result in greater benefits than other generally available Services, and will not approve such a request if the Service poses a significant risk to the health and safety of the Member. We will retain documentation of the criteria used to define a Service deemed to be Experimental/Investigational and will make this available for review upon request.

**Family Member**
Family Member means an Eligible Family Dependent who is properly enrolled in and entitled to Services under the Group Contract. For the purpose of ORS 743.730 the term “Member” satisfies the definition of “enrollee.”

**Grievance**
Grievance means a written complaint that may be submitted by or on behalf of a Member regarding the availability, delivery, or quality of health care Services, including a complaint regarding an adverse determination made pursuant to utilization review; claims payment; handling of reimbursement for health care Services; or matters pertaining to the contractual relationship between a Member and us.
**Group Contract**

Group Contract means the document issued by Providence Health Plan to the Employer and includes the provisions of the Employer/Group Agreement, Rate Summary, Member Handbook and Benefit Summaries, and any Endorsements or amendments that accompany these documents.

**Health Benefit Plan**

Health Benefit Plan means any Hospital or medical expense policy or certificate issued by a health care service contractor or health maintenance organization and any plan provided by a multiple Employer welfare arrangement or other benefit arrangement defined in the federal Employee Retirement Income Security Act (ERISA).

**Home Health Provider**

Home Health Provider means a public or private agency that specializes in providing skilled nursing Services and other therapeutic Services in the home and which has been licensed by the proper authority as a Home Health Agency, or is Medicare approved as a Home Health Agency.

**Hospital**

Hospital means an institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;
2. Has a physician or surgeon in regular attendance;
3. Provides continuous 24-hour-a-day nursing Services;
4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
5. Is legally operated in the jurisdiction where located; and
6. Has surgical facilities on its premises or has a contractual agreement for surgical Services with an institution having a valid license to provide such surgical Services.

Hospital does NOT include an institution that is principally a rest home, nursing home, Skilled Nursing Facility, convalescent home or home for the aged. Hospital does NOT include a place principally for the treatment of alcohol or Chemical Dependency or Mental Health disorders.

**Ineligible Person**

Ineligible Person means any person who does not qualify as a Member under the Group Contract.

**In-Plan**

In-Plan means the level of benefits specified in the Group Contract for Covered Services that are provided by a Participating Provider.
**Medically Necessary**

Medically Necessary means Services that are in the reasonable opinion of Providence Health Plan, consistent with the written criteria regarding medically indicated Services that are maintained by us. The criteria are based on the following principles:

1. The Service is medically indicated according to the following factors:
   - The Service is necessary to diagnose or to meet the reasonable health needs of the Member;
   - The expected health benefits from the Service are clinically significant and exceed the expected health risks by a significant margin;
   - The Service is of demonstrable value and that value is superior to other Services and to the provision of no Services; and
   - Expected health benefits can include:
     a. Increased life expectancy;
     b. Improved functional capacity;
     c. Prevention of complications; or
     d. Relief of pain.
2. The Qualified Practitioner recommends the Service.
3. The Service is rendered in the most cost-efficient manner and type of setting consistent with nationally recognized standards of care, with consideration for potential benefits and harms to the patient.
4. The Service is consistent in type, frequency and duration with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by us.

In the case of a life-threatening illness, a Service that would not meet the criteria above may be considered Medically Necessary for purposes of reimbursement, if:

- It is considered to be safe and effective, as demonstrated by accepted clinical evidence reported by generally-recognized medical professionals or publications; and
- The treatment is provided in a clinically controlled research setting using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health for a life-threatening condition.

For the purpose of this exception, the term “life-threatening” means more likely than not to cause death within one year of the date of the request for diagnosis or treatment.

**Member**

Member means a Subscriber, out-of-area Subscriber, Out-of-Area Dependent or Eligible Family Dependent, who is properly enrolled in and entitled to Services under the Group Contract. For the purpose of ORS 743.730 (13) the term “Member” means “enrollee.”
Mental Health
Mental Health means Services related to all disorders listed in the “Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition” except for:
- Diagnostic codes 317, 318.0, 318.1, 318.2 and 319 relating to Mental Retardation;
- Diagnostic codes 315.00, 315.1, 315.2 and 315.9 relating to Learning Disorders;
- Diagnostic codes 302.2, 302.4, 302.81, 302.82, 302.83, 302.84, 302.89 and 302.9 relating to Paraphilias;
- Diagnostic codes 302.6, 302.85 and 302.9 relating to Gender Identity Disorders in Adults. This exception does not extend to children and adolescents 18 years of age or younger; and
- Diagnostic codes V15.81 through V71.09, “V” codes. This exception does not extend to children five years of age or younger for diagnostic codes V61.20 (Parent-Child Relational Problem) through V61.21 (Neglect, Physical Abuse or Sexual Abuse of Child) and V62.82 (Bereavement).

Non-Participating Provider
Non-Participating Provider means an Outpatient Surgical Facility, Home Health Provider, Qualified Practitioner, Qualified Treatment Facility, Hospital or Skilled Nursing Facility that does not have a written agreement with us to participate as a health care provider under the Group Contract.

Open Enrollment Period
Open Enrollment Period means a period of at least 10 working days each Contract Year, agreed to by us and the Employer, during which Eligible Employees are given the opportunity to enroll themselves and their Eligible Family Dependents under the Plan for the upcoming Contract Year, subject to the terms and provisions as found in section 3.

Out-of-Area Dependent
Out-of-Area Dependent means an Eligible Family Dependent who:
   a) Does not reside* with the Subscriber; and
   b) Does not reside in the Service Area; and
   c) Is properly enrolled under the Group Contract as an Out-of-Area Dependent in accordance with our underwriting criteria.

* Includes an Eligible Family Dependent child attending school full time who meets the above criteria.

Out-of-Area Subscriber: See Subscriber definition.

Out-of-Pocket Maximum
See section 4.10.2.

Outpatient Surgical Facility
Outpatient surgical facility means any licensed public or private establishment that has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgery. It does NOT provide Services or accommodations for patients to stay overnight.

Participating Provider
Participating Provider means an Outpatient Surgical Facility, Home Health Provider, Qualified Practitioner, Qualified Treatment Facility, Hospital or Skilled Nursing Facility that has a written agreement with us to participate as a health care provider under the Group Contract. For Native American Members, Covered Services obtained through Indian Health Services are considered to be Covered Services obtained from a Participating Provider.
**Personal Physician/Provider**

Personal Physician/Provider means a Participating Provider specializing in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a physician assistant, when providing services under the supervision of a physician; who agrees to be responsible for the Member’s continuing medical care by serving as case manager. Adult female Members also may choose a provider specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women’s health care as their Personal Physicians/Provider. (Note: Not all Qualified Practitioners are Personal Physicians/Providers. To obtain a listing of Participating Personal Physicians/Providers please see the Provider Directory online or call Customer Service.)

**Portability Plans**

Portability Plan means an individual plan of continuation coverage, as specified in the Oregon Insurance Code, which is available to Oregon residents who lose coverage under a group Health Benefit Plan.

**Pre-existing Condition**

The Pre-existing Condition exclusion listed in section 4.11 applies only when the Group Contract is issued to a small employer, as specified in the Employer/Group Agreement.

A Pre-existing Condition means any medical condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the Member’s enrollment date in the Group Contract. For purposes of this definition, the enrollment date of a Member is the earlier of the Effective Date of Coverage or the first day of any required Eligibility Waiting Period. The limitations for a Pre-existing Condition under the Group Contract do not apply to:

1. Pregnancy;
2. Genetic information in the absence of a diagnosis of the condition related to such information;
3. Services provided to a newly born or adopted child who obtains coverage under the Group Contract as described in section 3; and
4. Members under the age of 19.

**Premium**

Premium means the monthly rates set by us as consideration for benefits offered under the Group Contract.

**Prior Authorization**

Prior Authorization or Prior Authorized means a request to us or our authorizing agent by you or by a Qualified Practitioner regarding a proposed Service, for which our prior approval is required. Prior Authorization review will determine if the proposed Service is eligible as a Covered Service or if an individual is a Member at the time of the proposed Service. To facilitate our review of the Prior Authorization request, we may require additional information about the Member's condition and/or the Services requested. We may also require that a Member receive further evaluation from a Qualified Practitioner of our choosing. Prior Authorization is subject to the terms and provisions of the Group Contract. Services that require Prior Authorization are shown in section 4.6.

Prior Authorized determinations are not a guarantee of benefit payment unless:

- A determination that relates to benefit coverage and medical necessity is obtained no more than 30 days prior to the date of the Service; or
- A determination that relates to eligibility is obtained no more than five business days prior to the date of the Service.

**Providence Health Plan**

Providence Health Plan means the nonprofit corporation authorized as a health care service contractor in the states of Oregon and Washington that issues the Group Contract to the Employer.
Qualified Practitioner
Qualified Practitioner means a physician, Women’s Health Care Provider, nurse practitioner, nurse practitioner midwife, clinical social worker, physician assistant, psychologist, dentist, or other practitioner who is professionally licensed by the appropriate governmental agency to diagnose or treat an injury or illness and who provides Covered Services within the scope of that license.

Qualified Treatment Facility
Qualified Treatment Facility means a facility, institution or clinic duly licensed by the appropriate governmental agency, which is primarily established and operating within the lawful scope of its license.

Rate Summary
Rate Summary means the document with that title which is part of this Group Contract and which summarizes the Premium provisions under this Group Contract.

Reconstructive Surgery
Reconstructive Surgery means surgery that restores features damaged as a result of injury or illness or to correct a congenital deformity or anomaly that results in a functional impairment.

Service
Service means a health care related procedure, surgery, consultation, advice, diagnosis, referrals, treatment, supply, medication, prescription drug, device or technology that is provided to a Member by a Participating Provider or a Non-Participating Provider.

Service Area
Service Area means the geographic area:

a) In Oregon, as specified in the Employer/Group Agreement, within which a group entity must be physically located in order to qualify as an Employer and recipient of the Group Contract.

b) In Oregon and southwest Washington, as specified in the Employer/Group Agreement, within which Subscribers, other than out-of-area Subscribers, must work or reside.

Skilled Nursing Facility
Skilled Nursing Facility means a convalescent or chronic disease facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or certified as a “Skilled Nursing Facility” by the Secretary of Health and Human Services pursuant to Title XVIII of the Social Security Act as amended.

Subscriber
Subscriber means an Eligible Employee who:

a) works or resides in the Service Area; or

b) works and resides outside* the Service Area; and

c) is properly enrolled in accordance with our underwriting criteria and participation requirements.

* Subscribers in this category are considered out-of-area Subscribers.

Supplemental Benefit
Supplemental Benefit means any benefit purchased by your Employer in addition to your Personal Option health care coverage. Examples are: prescription drug, alternative care, chiropractic care, vision care and elective sterilization. Not all Members have Supplemental Benefits. If your Plan includes coverage for Supplemental Benefits, your Member materials will include a Benefit Summary for each Supplemental Benefit.
Urgent/Immediate Care

Urgent/Immediate Care means Services that are provided for unforeseen, non-life threatening, minor illnesses and injuries which require immediate attention such as ear, nose and throat infections and minor sprains and lacerations.

Urgent/Immediate Care Covered Services are provided when your medical condition meets the guidelines for Urgent/Immediate Care that have been established by us. Covered Services do NOT include Services for the inappropriate use of an Urgent/Immediate Care facility, such as: Services that do not require immediate attention, routine check-ups, follow-up care, and prescription drug requests.

Usual, Customary and Reasonable (UCR)

When a Service is provided by a Participating Provider, UCR means charges based on the fee that we have negotiated with Participating Providers for that Service. UCR charges will never be less than our negotiated fees.

When a Service is provided by a Non-Participating Provider, UCR charges will based on the lesser of:
1. The fee a professional provider usually charges for a given Service;
2. A fee which falls within the range of usual charges for a given Service billed by most professional providers in the same locality who have similar training and experience;
3. A fee which is prevalent or which would not be considered excessive in a particular case because of unusual circumstances; or
4. The fee determined by comparing charges for similar Services to a national database adjusted to the geographical area where the Service was performed.

UCR charges do not include sales taxes, handling fees and similar surcharges and such taxes, fees and surcharges are not covered expenses.

Women’s Health Care Provider

Women’s Health Care Provider means an obstetrician or gynecologist, or physician assistant specializing in women’s health, advanced registered nurse practitioner specialist in women’s health or certified nurse midwife, practicing within the applicable lawful scope of practice.
IMPORTANT NOTICE

Recent federal and state legislation has resulted in changes to the provisions and covered services listed on your Benefit Summary.

Please refer to the Member Handbook Addendum that is included with your Member Handbook for a complete description of these changes.

If you have any questions, please contact Customer Service at:

• Portland-metro area: call 503-574-7500
• All other areas: call 1-800-878-4445
• TTY: 503-574-8702 or 1-888-244-6642

(Please scroll down to view the Benefit Summary.)
### Personal Option Plan Benefit Summary

<table>
<thead>
<tr>
<th>Co-Pay</th>
<th>What You Pay</th>
<th>Annual Out-of-Pocket Maximum</th>
<th>Annual Deductible</th>
<th>Lifetime Maximum Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10</td>
<td>20% coinsurance (after deductible)</td>
<td>$1,700 per person</td>
<td>$250 per person</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$5,100 per family (3 or more)</td>
<td>$750 per family (3 or more)</td>
<td>$2,000,000</td>
</tr>
</tbody>
</table>

#### Important information about your plan
This summary provides only highlights of your benefits. To view all your plan details, including your Member Handbook, register for myProvidence at [www.providence.org/php/getstarted](http://www.providence.org/php/getstarted)

- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- This plan only provides benefits for medically necessary services when provided by a participating physician or provider.
- A pre-existing condition exclusion applies to this plan. See the back for more information.
- This plan offers deductible carryover. This means any portion of your deductible(s) that you pay during the fourth quarter of the calendar year will be applied toward next year's deductible(s).
- Your deductibles, some services and penalties do not apply to out-of-pocket maximums.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

#### Personal Option Plan Benefit Highlights

<table>
<thead>
<tr>
<th>After you pay your annual deductible, then you pay the following for covered services:</th>
<th>Co-Pay or Coinsurance (from participating providers only)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician / Provider Services</strong></td>
<td></td>
</tr>
<tr>
<td>- Office visits</td>
<td>$10 / visit</td>
</tr>
<tr>
<td>- Periodic health exams; well-baby care</td>
<td>$10 / visit</td>
</tr>
<tr>
<td>(from a Personal Physician/Provider only)</td>
<td></td>
</tr>
<tr>
<td>- Routine immunizations; shots</td>
<td>$10 / visit</td>
</tr>
<tr>
<td>- Allergy shots; serums; injectable medications</td>
<td>20%</td>
</tr>
<tr>
<td>- Inpatient hospital visits</td>
<td>20%</td>
</tr>
<tr>
<td>- Surgery; anesthesia</td>
<td>20%</td>
</tr>
<tr>
<td>- Other office procedures</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Women's Health Services</strong></td>
<td></td>
</tr>
<tr>
<td>- Annual gynecological exams (calendar year); Pap tests</td>
<td>$10 / visit</td>
</tr>
<tr>
<td>- Follow-up visits after annual gynecological exam</td>
<td>$10 / visit</td>
</tr>
<tr>
<td>- Mammograms</td>
<td>$10</td>
</tr>
<tr>
<td><strong>Hospital Services</strong></td>
<td></td>
</tr>
<tr>
<td>- Inpatient care</td>
<td>20%</td>
</tr>
<tr>
<td>- Observation care</td>
<td>20%</td>
</tr>
<tr>
<td>- Rehabilitative care (30 days per calendar year)</td>
<td>20%</td>
</tr>
<tr>
<td>- Skilled nursing facility (60 days per calendar year)</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
<td></td>
</tr>
<tr>
<td>- Pre- and post-natal visits; delivery</td>
<td>$100</td>
</tr>
<tr>
<td>- Routine newborn nursery care</td>
<td>20%</td>
</tr>
<tr>
<td>- Hospital services</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic Devices</strong></td>
<td></td>
</tr>
<tr>
<td>(Removable custom shoe orthotics are limited to $200 per calendar year)</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Emergency/Urgent Care/Ambulance Services</strong></td>
<td></td>
</tr>
<tr>
<td>(Your emergency/urgent co-pay is waived if admitted to the hospital within 24 hours)</td>
<td></td>
</tr>
<tr>
<td>- Emergency services (for emergency medical conditions only)</td>
<td>$125</td>
</tr>
<tr>
<td>- Urgent care services (for non-life threatening illness/minor injury)</td>
<td>$25</td>
</tr>
<tr>
<td>- Ambulance services (for emergency transportation only)</td>
<td>20%</td>
</tr>
</tbody>
</table>

*Your deductible(s) do not apply to purchases of diabetes supplies.*
Personal Option Plan Benefit Highlights (continued)

### Other Covered Services

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Co-Pay or Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-ray; lab services</td>
<td>20%✓</td>
</tr>
<tr>
<td>Imaging services (PET, CT, MRI)</td>
<td>20%✓</td>
</tr>
<tr>
<td>Outpatient rehabilitative services (30 visits per calendar year)</td>
<td>20%</td>
</tr>
<tr>
<td>Outpatient surgery; dialysis; infusion, chemotherapy; radiation therapy</td>
<td></td>
</tr>
<tr>
<td>Temporomandibular joint (TMJ) service</td>
<td>50%</td>
</tr>
<tr>
<td>(limited to $1,000 per calendar year / $5,000 per lifetime)</td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>20%</td>
</tr>
<tr>
<td>Hospice care</td>
<td></td>
</tr>
<tr>
<td>Self-administered chemotherapy</td>
<td></td>
</tr>
<tr>
<td>(Up to a 30-day supply from a designated participating pharmacy)</td>
<td></td>
</tr>
<tr>
<td>- Generic drugs</td>
<td>$10✓</td>
</tr>
<tr>
<td>- Formulary brand-name drugs</td>
<td>$50✓</td>
</tr>
<tr>
<td>- Non-formulary brand-name drugs</td>
<td>$100✓</td>
</tr>
</tbody>
</table>

### Mental Health / Chemical Dependency

(To initiate services, you must call 1-800-711-4577. All inpatient, residential and day or partial hospitalization treatment services must be prior authorized.)

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Co-Pay or Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient, residential and day treatment services</td>
<td>20%</td>
</tr>
<tr>
<td>Outpatient provider visits</td>
<td>$10 / visit✓</td>
</tr>
</tbody>
</table>

### Your guide to the words or phrases used to explain your benefits

#### Coinsurance
The percentage of the cost that you may need to pay for a covered service.

#### Copay
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

#### Deductible
The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a calendar year. The following expenses do not apply to an individual or family deductible:

- Services not covered by your plan
- Services that exceed your plan’s lifetime maximum benefit
- Fees that exceed usual, customary and reasonable (UCR) charges as established by your plan
- Penalties incurred if you do not follow your plan’s prior authorization requirements
- Co-pays or coinsurance for any supplemental benefits provided by your employer, such as prescription drugs, or routine vision care

#### Deductible carryover
A feature of your plan that allows for any portion of your deductible that is paid during the fourth quarter of a calendar year to be applied toward the next year’s deductible.

#### Formulary
A list of preferred brand name and generic drugs that have been evaluated by us for effectiveness and safety.

#### Lifetime maximum benefit
The total dollar amount of benefits that you can receive from your plan during your lifetime.

#### Non-participating provider
Any health care professional who does not participate in Providence Health Plan’s network of participating physicians and providers of health care services.

#### Out-of-pocket maximum
The limit on the dollar amount you will have to spend for specified covered health services in a calendar year. Some services and expenses do not apply to the out-of-pocket maximum. See your Member Handbook for details.

#### Participating provider
A physician or provider of health care services who belongs to the Providence Health Plan participating provider network. To find a participating provider, go to the online directory at www.providence.org/php/providerdirectory

#### Pre-existing condition
A medical condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to your effective date of coverage. You will need to be covered under this plan for six continuous months before services for pre-existing conditions will be covered. See your Member Handbook for details.

#### Self-administered chemotherapy
Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

---

Contact us
Headquartered in Portland, our customer service professionals have been proudly serving our members since 1986.

Portland Metro Area: 503-574-7500
All other areas: 1-800-878-4445
TTY: 503-574-8702 or 1-888-244-6642

Have questions about your benefits and want to contact us via e-mail? Go to our Web site at: www.providence.org/php/contactus

PGC-OR 1008 SG PED1
Oregon - Small Group

PER-398add
PE 10/20/1700 250d add
Your Benefit Summary
Prescription Drug Plan

Important information about your plan
This summary provides only highlights of your pharmacy benefits. Certain limitations and exclusions apply. To view all your plan details, including your Member Handbook, register for myProvidence at www.providence.org/php/getstarted

- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online or call us.
- You have broad access to over 22,000 participating pharmacies and their services at discounted rates. Pharmacies are designated as participating retail, preferred retail, specialty, or mail order pharmacies.
- View a list of participating pharmacies, including specialty pharmacies, at www.providence.org/healthplans or call us.
- Not sure what a word or phrase means? See the back for definitions used in this summary.
- Co-pays, coinsurance and any difference in costs for prescription drugs do not apply to your annual medical plan out-of-pocket maximums or deductibles.
- The pharmacy benefits used under your plan apply to your lifetime maximum benefit. See your Member Handbook for details.

<table>
<thead>
<tr>
<th>Drug Coverage Category</th>
<th>Co-Pay or Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic drug</td>
<td>$10 $10 $10</td>
</tr>
<tr>
<td>Brand name drug</td>
<td>$20 $20 $20</td>
</tr>
<tr>
<td>Compounded drug</td>
<td>50% Does not apply $20</td>
</tr>
</tbody>
</table>

What you need to know about drug coverage categories
- Both generic and brand name drugs are covered subject to the terms of your plan.
- Some medications are less costly. If the cost of your prescription is less than your copay, you will only be charged the cost of the prescription.
- If you or your physician request a brand name drug when a generic is available, you will be responsible for paying the cost difference, in addition to your brand-name drug co-pay.
- Compounded drugs are prescriptions that are custom prepared by your pharmacist. These prescriptions must contain one Food and Drug Administration (FDA) approved drug.
- Specialty drugs are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist.
- Self-administered chemotherapy drugs are covered under your pharmacy benefits or your medical benefits, whichever allows for your lowest out-of-pocket cost. Please refer to your medical summary of benefits for more information.

Using your prescription drug benefit
- Your prescription drug benefit requires that you fill your prescriptions at a participating pharmacy.
- Be sure you present your current Providence Health Plan member identification card, along with your co-pay or coinsurance when you use a participating pharmacy.
- You may purchase up to a 90-day supply of maintenance drugs using a participating mail service or preferred retail pharmacy. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.
- Most specialty and chemotherapy drugs are only available at our designated specialty pharmacies. For more information visit our Web site at www.providence.org/healthplans.
- Diabetes supplies may be obtained at your participating pharmacy and are subject to your group’s medical supplies and devices benefits, limitations and coinsurance. See your Member Handbook for details.

Using your prescription drug formulary
- The Providence Formulary is a list of FDA approved prescription brand name and generic drugs developed by physicians and pharmacists. It is designed to offer drug treatment choices for covered medical conditions.
- Some prescription drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy, or number of doses. If a drug to treat your covered medical condition is not on the Formulary, please contact us.
- Our Formulary can help you and your physician choose effective medications that are less costly and minimize your out-of-pocket expense.
- Effective generic drug choices are available to treat most medical conditions. Visit www.providence.org/healthplans for frequently asked questions about both generic drugs and our Formulary.
Ordering prescriptions by mail

- To order prescriptions by mail, your provider may call in the prescription or you can mail your prescription along with your member identification number to one of our participating mail order pharmacies.
- To find participating mail order pharmacy information visit us online at www.providence.org/healthplans

If you use a non-participating pharmacy

- Urgent or emergency medical situations may require that you use a non-participating pharmacy.
- If this occurs, you will need to pay full price for your prescription at the time of purchase. Reimbursement forms are available online.
- Reimbursement is subject to your plan’s limitations and exclusions.

What you need to know about limitations and exclusions

The following is a summary of the limitations and exclusions under your prescription drug plan. For complete descriptions go to: www.providence.org/healthplans

Limitations

- All drugs must be Food and Drug Administration (FDA) approved, medically necessary, and require by law, a prescription to dispense. Not all FDA approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety and medical necessity within 12 months following FDA approval.
- Prescription dispensing limits: 1) topicals—up to 60 grams; 2) liquids—up to eight ounces; 3) tablets or capsules—up to 100 dosage units; and 4) multi-use or unit-of-use—up to one container or package; as prescribed, not to exceed a 30 consecutive day supply, whichever is less. Other dispensing limits may apply to certain medications requiring limited use and are listed on our Formulary.
- Specialty drugs are injectable, infused, oral or inhaled therapies that often require specialized delivery, handling, monitoring and administration, and are generally high cost. These drugs must be purchased through our designated Specialty Pharmacy. Due to the nature of these medications, they are not considered “maintenance” drugs and are limited to a 30-day supply (or minimum package size to approximate a 30-day supply). For a copy of our “Specialty Medications” list visit www.providence.org/healthplans, or call us.
- Self-injectable drugs are only covered if they are intended for self-administration, labeled by the FDA for self-administration and on our list of “Specialty Medications.”

Exclusions

- Drugs used in the treatment of fungal nail conditions.
- Drugs used in the treatment of the common cold.
- Experimental or investigational drugs or drugs used by a member in a research study or in another similar investigational environment.
- Intrauterine devices (IUDs), diaphragms and implantable contraceptives. Some of these items may be covered under your medical benefits.
- Drugs or medications delivered, injected or administered for you by a physician, other provider or another trained person.
- Drugs prescribed by naturopathic physicians (N.D.).
- Amphetamines and amphetamine derivatives, except when used in the treatment of narcolepsy or hyperactivity in children and adults.
- Drugs or medications used to treat sexual dysfunctions or disorders, in either men or women, such as Viagra® or drugs required for, or as a result of, sexual transformation.
- Drugs used for the treatment of fertility or infertility.
- Fluoride, for members over the age of 10 years old.
- Replacement of lost or stolen medication.
- Drugs used for weight loss or cosmetic purposes.
- Medications prescribed that do not relate directly to the treatment of a covered illness or injury.
- Over-the-Counter (OTC) drugs, medications or vitamins that may be purchased without a provider’s written prescription and prescription drugs that are available in an OTC therapeutically similar form.
- Devices, appliances, supplies and durable medical equipment, even if a prescription is required for purchase. These items may be covered under your medical benefits.
- Smoking cessation drug therapy, including nicotine replacement therapy. (Your PHP health coverage provides access to discounted smoking cessation programs, including drug therapy.)
- Drugs dispensed from pharmacies outside the United States, except for urgent and emergency medical conditions.
- Drugs or prescribed medications that are not medically necessary or are not provided according to our medical policy.
- Drugs to stimulate hair growth, including, but not limited to, Rogaine® (i.e., topical minoxidil) or other similar drug preparations.
- Drugs used in the treatment of drug induced fatigue, general fatigue and idiopathic hypersomnia.
- Drugs that are not FDA approved or designated as “less than effective” by the FDA, also known as a “DESI” drug.
- Drugs placed on prescription-only status as required by state or local law.
Your guide to the words and phrases used to explain your benefits

**Brand-name drug**
Brand name drugs are protected by U.S. patent laws for up to 17 years, so only the pharmaceutical company that holds the patent has exclusive rights to produce and sell them.

**Coinsurance**
The percentage of the cost that you pay to a participating pharmacy, at the time of purchase, for a covered prescription drug.

**Compounded drug**
The combining, mixing, or altering of covered drugs or other ingredients for a customized prescription for an individual as prescribed by a licensed provider.

**Co-pay**
The fixed dollar amount you pay to a participating pharmacy, at the time of purchase, for a covered prescription drug.

**Formulary**
A formulary is a list of FDA approved prescription drugs developed by physicians and pharmacists, designed to offer drug treatment choices for covered medical conditions. The Providence Health Plan Formulary includes both brand name and generic medications.

**Generic drug**
Generic drugs have the same active-ingredient formula as the brand name drug. Generic drugs are tested by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs. Generic drugs are only available after the brand name patent expires. Visit www.providence.org/healthplans for frequently asked questions about generic drugs.

**Maintenance drug**
Medications that are typically prescribed to treat long-term or chronic conditions, such as diabetes, high blood pressure and high cholesterol. Maintenance drugs are those that you have received under our plan for at least 30 days and that you anticipate continuing to use in the future.

**Participating pharmacies**
Pharmacies that have a signed contract with Providence Health Plan to provide medications and other services at special rates. There are four types of participating pharmacies:
- **Retail**: a participating pharmacy that allows up to a 30-day supply of short term and maintenance prescriptions.
- **Preferred Retail**: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short term prescriptions.
- **Specialty**: a participating pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.
- **Mail Order**: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.

For a complete description of the types of services provided by participating pharmacies, see your Member Handbook.

**Prior authorization**
The process used to request an exception to the Providence Health Plan drug formulary. This process is initiated by the prescriber of the medication. Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses. Visit www.providence.org/healthplans for additional information.

**Self-administered chemotherapy**
Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

---

**Contact us**
Headquartered in Portland, our customer service professionals have been proudly serving our members since 1986.

Portland Metro Area: **503-574-7500**
All other areas: **1-800-878-4445**
TTY: **503-574-8702** or **1-888-244-6642**

Have questions about your benefits and want to contact us via e-mail? Go to our Web site at: www.providence.org/php/contactus