

This Member Handbook Addendum clarifies certain rights and benefits for Oregon Group members.

Your Member Handbook is not complete without this addendum. The information reflected in this addendum shall supersede in the event of conflict with the Member Handbook.

## **Understanding Your Deductibles and Out-of-Pocket Maximums, Calendar year Out-of-Pocket maximums, *out-of-pocket costs that do not apply to annual out-of-pocket maximums***

*In the above section of your handbook, please replace existing text with the following:*

*out-of-pocket costs  
that do not apply to  
annual out-of-pocket  
maximums*

**The following out-of-pocket costs do not apply toward your annual out-of-pocket maximums:**

- Services not covered by Providence Health Plan.
- 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 Summary of Benefits as not applicable to the out-of-pocket maximum.
- Durable medical equipment and medical supplies and devices.
- Tobacco use cessation services.
- 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:** The above-listed covered services not applicable to the out-of-pocket maximum are NOT eligible for 100 percent benefit coverage. The copayment or coinsurance for these services as shown on your Summary of Benefits remains in effect throughout the calendar year.

## **Covered Services, Medical and diabetes supplies, durable medical equipment, appliances, prosthetic devices**

*In the above section of your handbook, please add the following:*

- **Hearing aids for dependent children** – Covered for Medically necessary external hearing aids and devices, one per ear, prescribed by a licensed audiologist and received from an approved provider are covered for dependent children younger than 18 years of age 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 benefit does not apply to enrolled subscribers, spouses or domestic partners.

## **Covered Services, Other covered services**

*In the above section of your handbook, please add the following:*

***tobacco use cessation services*** Coverage is provided for Members 15 years of age and older for participation in a Providence Health Plan-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 Providence Health Plan-approved programs is available online at [www.providence.org/healthplans](http://www.providence.org/healthplans), and by calling Customer Service at 503-574-7500 or 1-800-878-4445. A 20 percent coinsurance applies to all tobacco use cessation services and does not apply to your out-of-pocket maximums. Coverage is limited to \$500 per member per lifetime.

## **Exclusions, Exclusions that apply to mental health and chemical dependency services:**

*In the above listed section, please strike the following:*

- More than one **long-term residential *Mental Health* program**, lasting a maximum of 45 days, within a calendar year.

*and replace with the following:*

- **Residential Mental Health Services or Chemical Dependency Services** in excess of 60 days per calendar year.

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# Welcome to Providence Health Plan

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**Introduction** 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.

**Your Open Option plan** Your Open Option plan allows you to receive all covered services from participating providers through what is called your “In-Plan” benefit. You also have the option to receive most covered services from non-participating providers through what is called your “Out-of-Plan” benefit. Generally, your out-of-pocket costs will be less when you receive covered services from participating providers. Also, participating providers will work with us to prior authorize treatment. If you receive services from non-participating providers, it is your responsibility to make sure the services listed on page 15 are prior authorized by us before treatment is rendered.

**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.**

If you are unsure about a physician/provider’s, hospital’s or other facility’s participation with Providence Health Plan, visit our Online Participating Provider Directory for Open Option Plan members at [www.providence.org/healthplans](http://www.providence.org/healthplans) before you make an appointment. You also can call your Customer Service team to get information about a provider’s participation with Providence Health Plan.

**Whenever you visit a participating provider:**

- Bring your Providence Health Plan member identification card with you.
- If your office visit is subject to a copayment, you will need to make that copayment at the time of your visit.
- If your office visit is subject to a percent of billed 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 for an estimate of what you may owe at the time you receive services, and bill or credit you for the balance later.

# Welcome to Providence Health Plan

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## About this handbook

This handbook contains important information about the health insurance we offer to Oregon employers and their employees. It is important to read this handbook carefully as it explains your Providence Health Plan benefits and your responsibilities as a Providence Health Plan member. If you don't understand a term that is used, you may find it in "*definitions*," pages 84-87. To help you find specific information, an index is located in the back of this book. If you need additional help understanding anything in this handbook, please call your Customer Service team at 503-574-7500 or 1-800-878-4445. See "*customer service*," page 3, for additional information on how to reach your Customer Service team.

### **This handbook is not complete without your:**

- **Open Option Summary of Benefits** and any other supplemental Summary of Benefits documents. These materials are available online at [www.providence.org/healthplans](http://www.providence.org/healthplans) when you are registered for a myProvidence account (see page 3). These materials list in detail your member copayments/coinsurance for covered services and also give you important information for any supplemental benefits you have (like prescription drugs or vision).
- **Online Participating Provider Directory.** Participating providers are listed on our Web site at [www.providence.org/healthplans](http://www.providence.org/healthplans). You will need this directory to access covered services from participating providers. If you do not have Internet access, please call your Customer Service team or check with your employer's human resource department to obtain a paper directory.

Occasionally, you may need more detailed information for a specific problem or situation. If this occurs, ask your employer or your Customer Service team for a copy of the **Employer Group Contract** – a legal document which explains your benefits, rights and obligations in more detail.

# Customer Service

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## **Your Customer Service team**

We want you to understand how to use your Providence Health Plan benefits. We also want you to be satisfied with your health plan. Your Customer Service team is here to help you understand your benefits and resolve any problems you may have. Your Customer Service team will handle:

- 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.

## **How to contact your Customer Service team**

Here is all you need to do to get in touch with your Customer Service team:

- **Have your Providence Health Plan member identification card ready when you call. Your card lists your member number.**
- **If you live in:**
  - **Portland-metro area: Call 503-574-7500**
  - **All other areas: Call 1-800-878-4445**
- **For TTY (Telecommunication services for the hearing impaired), please call 503-574-8702 or 1-888-244-6642.**
- **Follow the easy-to-use menu selections to be connected to your Customer Service team or to access your claims and benefit information via our voice-recognition phone system.**

Your Customer Service team is available from 8 a.m. to 5 p.m., Monday through Friday, excluding holidays. In addition, our automated voice-recognition phone system is available during non-business hours for you to access claims and benefit information, seven days a week.

## **Registering for a myProvidence account**

Your member materials, including your Summary of Benefits and Member Handbook, are available on our Web site when you register for a myProvidence account at [www.providence.org/healthplans](http://www.providence.org/healthplans). When you register for a myProvidence account, you can view your personal health plan information, view claims history and payment, order a replacement member identification card, and access other health and wellness tools and services.

## General Information

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### Member identification card

Each member of Providence Health Plan receives a member identification card. Your member identification card lists information about your health plan coverage, including:

- your member number and group number
- your particular health plan
- important phone numbers

**\*Supplemental benefits** are any benefits purchased by your employer in addition to your Open Option health care coverage (e.g., prescription drug, alternative care, chiropractic care, vision and elective sterilization). Your member identification card will not list all of your supplemental benefits. If your plan includes coverage for supplemental benefits, your member materials will include a Summary of Benefits for each supplemental benefit.

When scheduling an appointment or receiving health services, identify yourself as a Providence Health Plan member, present your member identification card and pay your copayment or coinsurance.

#### **Please keep your health plan member card with you and use it when you:**

- Have appointments with your health care provider.
- Call for mental health/chemical dependency customer service.
- Call or write your Customer Service team.
- Call Providence RN, our medical advice line.
- Visit your pharmacy for prescriptions.
- Receive urgent or emergency health care.

### Providence RN

#### **Providence RN — 503-574-6520; 1-800-700-0481**

Providence RN is a free medical advice line for Providence Health Plan members. You may call Providence RN at 503-574-6520 (Portland-metro area) or 1-800-700-0481 (all other areas) with your health-related questions and speak to a registered nurse, 24 hours a day, seven days a week. For TTY (telephone device for the hearing impaired), call 1-800-735-2900 (Oregon Relay for TTY). Please have your member identification card available when you call.

Members often call when they have sick children at home, or when they have questions about how to treat flus, colds or backaches. After a brief recorded message, a registered nurse will come on the line to help. The nurse can answer many of the questions you may have or let you know whether you should seek a doctor's care.

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

## General Information

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### Wellness benefits

#### **Providence Resource Line — 503-574-6595; 1-800-562-8964**

Providence Resource Line is your connection to information and services on classes, self-help materials, stop-smoking services, and for referrals to Providence Health Plan participating providers and to Providence Health & Services programs and services. Services and health education vary by geographic service area.

#### **Health Education**

No matter what your health-related interest, you will find a wide variety of classes to help ensure your success. We can assist you in learning to eat right and manage your weight, preparing for childbirth, learning how to quit smoking and much more. If you have diabetes, health education classes also are available. See “*members diagnosed with diabetes*,” page 28, for further information.

Providence Health Plan members receive discounts on health education classes supporting smoking cessation, childbirth education and weight management. Your costs, services and the health education classes available may vary by geographic service area. For more information on classes available in your area, call the Providence Resource Line at 503-574-6595 or 1-800-562-8964 or visit [www.providence.org/classes](http://www.providence.org/classes).

#### **Wellness information on our Internet site —**

#### **[www.providence.org/healthplans](http://www.providence.org/healthplans)**

Visit us online at [www.providence.org/healthplans](http://www.providence.org/healthplans) for medical information, class information, information on extra values and discounts and a wide array of other information listed with your good health in mind. You also may set up your own myProvidence account to gain access to your specific personal health plan information. See *Registering for a myProvidence account* on page 3 for more details.

#### **LifeBalance — 503-234-1375 or 1-888-754-LIFE**

#### **[www.LifeBalanceProgram.com](http://www.LifeBalanceProgram.com)**

This program, exclusively for members of Providence Health Plan, provides discounts on a variety of recreational, cultural and wellness activities throughout Oregon and southwest Washington. You'll save on professional instruction, rentals, fitness club memberships, musical events, and much more. Members also have access to discounted member events, such as white-water rafting, ski trips, theater nights and sporting events.

Learn more by visiting LifeBalance at [www.LifeBalanceProgram.com](http://www.LifeBalanceProgram.com), or call LifeBalance at 503-234-1375 or 1-888-754-LIFE for a printed directory of discount providers. Please have your Providence Health Plan member identification card ready when you request LifeBalance discounts.

# Eligibility

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## **Introduction**

This section answers questions you may have about which members of your family are covered by your health plan.

## **Subscriber requirements**

Employers decide when their employees are eligible for health care coverage. They may require you to work a certain length of time (a probationary/introductory period) before you qualify. If a probationary period exists, it will be outlined in the Employer Group Contract on file with your employer.

**Coverage for a subscriber and any eligible 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.**

- The subscriber's absence must be within the employer's policies and practices as defined in the Employer Group Contract;
- The employer's leave of absence policy must comply with the Oregon Family and Medical Leave Act, the federal Family and Medical Leave Act; or the Uniformed Services Employment and Reemployment Rights Act;
- 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.

## **Eligible dependents**

**The subscriber's dependents may be eligible for coverage.**

**Those eligible include:**

- The subscriber's legal spouse or Domestic Partner\*;
- The subscriber's unmarried, biological child, step-child or legally adopted child;
- A grandchild for whom the subscriber or the subscriber's spouse provides at least 50 percent support;
- A child for whom the subscriber or the subscriber's spouse is a legal guardian, while providing at least 50 percent support;
- A child placed for adoption with the subscriber or subscriber's spouse for the purpose of adoption;
- 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.

Specific terms of dependent eligibility vary by employer group. Please contact your employer's group benefits office for eligibility information.

*\*Note:* All provisions of this group health plan that apply to spouses apply to Oregon Registered Domestic Partners. Your employer may have extended these provisions to non-Oregon Registered Domestic Partners by supplemental endorsement.

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***limiting age*** The limiting age is the age at which a dependent child is no longer eligible for coverage under this group health plan. Your child's coverage will end on the last day of the month in which they reach the limiting age.

Dependent children who are in regular full-time attendance at an accredited secondary school, trade school, college or university are no longer eligible for coverage on the last day of the month in which they attain the limiting age, or on the last day of the month in which they are no longer in regular full-time attendance.

Your employer determines the limiting age for your plan. Your human resources department and your Customer Service team can assist you with questions about your plan's limiting age.

***incapacitated dependent child*** An incapacitated dependent child is one who is incapable of self-support because of mental or physical disability. Coverage for incapacitated dependent children can be continued past the limiting age if the dependent's incapacitating condition existed before the child reached the limiting age. This only applies to the subscriber's unmarried, biological child, step-child or legally adopted child, or a child for whom the subscriber or the subscriber's spouse is a legal guardian, while providing at least 50 percent support.

*For example, you have a 30-year-old incapacitated dependent who has been incapacitated since birth. That dependent would be eligible for coverage because they became incapacitated prior to the limiting age.*

Your benefit plan will not provide coverage for dependents who become incapacitated after the limiting age. *For example, you have a 30-year-old dependent who became incapacitated at age 27 after a motorcycle accident. The limiting age for your plan is 23. This incapacitated dependent would not be eligible for coverage under your benefits, as she or he became incapacitated after your plan's limiting age.*

Within 60 days of an eligible dependent child reaching the limiting age, we will require satisfactory proof that the conditions listed above exist. If we do not receive satisfactory proof, the child's coverage will not continue beyond the last date he or she was eligible.

### **Newly-acquired dependents**

#### ***newborn and adopted children***

**This section only applies if your employer group allows dependent coverage.**

Newborn or adopted children who meet the requirements and definition as described in "*eligible dependents*," page 6, are eligible for coverage from the date of birth or placement for the purpose of adoption.

Enrollment and payment of any necessary additional premium must occur within 60 days from birth or placement. If the enrollment and payment are not accomplished within this time period, claims for covered services for the newborn or adopted child will be denied.

***new spouse*** Your new spouse is eligible for coverage on the first day of the calendar month following our receipt of the enrollment request or on an earlier date as agreed to by Providence Health Plan.

## Eligibility

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### Members no longer eligible for coverage

If you divorce, your spouse is no longer eligible for coverage as a dependent. You must disenroll your spouse as a dependent from your group coverage at the time the divorce is final, or at the time specified on your Employer Group Contract.

If an enrolled child marries or is no longer eligible for coverage under your employer's plan, you must disenroll the child when he or she becomes ineligible.

You must inform your employer of these changes by completing a new enrollment form. Those who no longer qualify as your dependents may be eligible to continue coverage as described under "*continuation and portability coverage*," pages 68-71. Ask your employer or call your Customer Service team for eligibility information on continuation of coverage.

Check with your employer's benefits office to determine the effective date of any changes other than those specified above.

### 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 your Customer Service team or via our Web site.

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 dependents when:

- You marry and wish to enroll your new spouse;
- A dependent's qualifying age occurs; or
- You or one of your dependents has a legal name change.

If you have questions regarding eligibility changes, please contact your Customer Service team.

### Special enrollment periods

If you have declined enrollment for yourself or your eligible family dependents because of other health insurance coverage, you may be eligible to enroll yourself or your dependents on Providence Health Plan during a special enrollment period provided that your other health coverage ended for one of the following reasons:

- The other coverage was under a COBRA Continuation provision and the coverage was exhausted -- unless the COBRA coverage terminated as a result of failure to pay timely premium -- or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact) and you apply for this plan within 30 days; or
- The other coverage was not under a COBRA Continuation provision and terminated as a result of:
  1. A legal separation; divorce; death; termination of employment; or a reduction in the number of hours of employment; unless the coverage was terminated as a result of failure to pay timely premium, or for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact) and you apply for this plan within 30 days; or
  2. The current or former employer contributions towards such coverage were terminated and you apply for this plan within 30 days; or

## Eligibility

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3. A court has ordered that coverage be provided for a spouse or minor child and request for enrollment is made within 30 days after the issuance of the court order; or
4. Coverage under 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, was involuntarily terminated within 63 days of applying for coverage in this plan; or
5. You incur a claim that exceeds the lifetime limit on all benefits and you apply for coverage within 30 days after the claim is denied.

In addition, when an eligible dependent qualifies for one of these special enrollment periods, the subscriber and all the eligible family dependents may either:

- Enroll in the coverage currently elected by the subscriber; or
- If your employer offers more than one benefit option, enroll in any benefit option for which the subscriber and dependents are eligible.

Also, if you were eligible to enroll as a subscriber, but did not enroll during a previous enrollment period for any reason, and an individual becomes your dependent through marriage, birth, adoption or placement for adoption, we will allow you and any other eligible dependents the opportunity to enroll as long as you request enrollment within 30 days of the marriage, birth, adoption or placement for adoption in which case, coverage will become effective:

- in the case of marriage, on the first day of the calendar month following our receipt of the enrollment request;
- in the case of a dependent's birth, adoption or placement for adoption, on the date of such birth; adoption or placement for adoption; or
- in the case of legal guardianship of a dependent, the date such legal guardianship status begins.

Special enrollment periods and rights can be confusing. If you have questions regarding special enrollment periods or eligibility changes for you or your dependents, please contact your Customer Service team.

# Using Your Participating Provider Benefits

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**Introduction** This section summarizes basic information you need to know to take advantage of the services offered by Providence Health Plan Participating Providers.

**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 In-Plan benefits to be covered, you must receive health care 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.**

**Nationwide network of participating providers** Providence Health Plan also has contractual arrangements with certain physicians/providers, hospitals and facilities located outside our Oregon and southwest Washington service area. These arrangements allow you to receive benefits under your In-Plan copayments and coinsurances, even when you are outside the Providence Health Plan service area.

**Choosing a participating provider** To choose a participating provider, or to verify if a provider is a participating provider go to our Online Participating Provider Directory at [www.providence.org/healthplans](http://www.providence.org/healthplans) and select as your plan type “Open Option Providers.” See our instructions for finding a physician, provider or facility on the opening page of this handbook for additional details. If you do not have access to our Web site, please call your Customer Service team to request participating provider information.

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 page 15-16.*

**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 through participating facilities and providers. For a list of these facilities, please either visit the IHS Web site at [www.ihs.gov](http://www.ihs.gov), or contact the regional IHS office at:*

Portland Area Indian Health Service  
1220 SW Third Ave #476  
Portland, OR 97204  
Telephone: 503-326-4123  
Fax: 503-326-7280

# Using Your Personal Physician/Provider Benefits

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**Introduction** 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 personal physician/provider as soon as possible.

**Personal physicians/providers** A personal physician/provider is a physician who specializes in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; a certified nurse midwife; 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 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.

When you select a participating personal physician/provider, your out-of-pocket costs for office visits will generally be lower. You can, however, select a non-participating personal physician/provider. When you do this, your out-of-pocket costs will generally be higher. The choice is up to you.

**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 see our Online Participating Provider Directory for a listing of designated participating personal physicians/providers or call your Customer Service team to obtain a paper copy.

## Using Your Personal Physician/Provider Benefits

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### **Established patients with personal physicians/providers**

If you and your family already see a provider who meets the definition of a personal physician/provider, please 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.

### **Selecting a new personal physician/provider**

If you don't have a regular personal physician/provider or your provider is not a participating provider with Providence Health Plan, we recommend you choose one from our Online Participating Provider Directory for each covered member of your family. Call the provider's office to make sure he or she is accepting new patients.

Soon after you select your personal physician/provider, it is a good idea to have your previous physician or provider transfer your medical records to your new personal physician/provider. 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. Also, inform your personal physician/provider of any ongoing prescription medications you are currently taking.

### **Changing your personal physician/provider**

You are encouraged to establish an ongoing relationship with your personal physician/provider. We understand, however, how important it is for you and your family to feel confident in your choice of providers. If you decide to change your personal physician/provider, please remember to have your medical records transferred to your new personal physician/provider.

### **Office visits**

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 personal physician/provider on call may treat you and/or recommend that you see another provider who specializes in treatment for your condition.

# Using Your Non-Participating Provider Benefits

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## Non-participating providers

As an Open Option Plan member, you may choose to seek care through participating providers using your In-Plan benefit or seek care through non-participating providers by using your Out-of-Plan benefit. *(Some services are covered only when you use your In-Plan benefit, see your Summary of Benefits for details.)* **Generally, when you receive services from non-participating providers, your member coinsurance payments will be higher than when you see participating providers.** It is usually to your advantage to use your In-Plan benefits whenever you can. Your Out-of-Plan benefits are described in the “Out-of-Plan” column on your Summary of Benefits.

## Approved non-participating provider categories

When you use non-participating providers, Providence Health Plan provides benefits for covered medically necessary care only when it is received from providers or facilities in approved categories, and when the provider is practicing within the scope of his or her license.

Providence Health Plan has approved and may provide reimbursement for non-participating qualified practitioners and facilities. Qualified practitioners are defined as a physician, women’s health care provider, nurse practitioner, clinical social worker, physician assistant, psychologist, dentist, or other practitioner who is professionally licensed by the appropriate state agency to diagnose or treat an injury or illness and who provides services covered by Providence Health Plan within the scope of that license. A qualified facility is defined as a facility, institution or clinic duly licensed by the appropriate state agency, which is primarily established and operating within the lawful scope of its license.

**IMPORTANT NOTE:** While Providence Health Plan will provide reimbursement for covered services received by any approved providers listed above, for benefits to be paid you must receive medically necessary covered services as listed in this handbook. All treatment, supplies, and medications excluded by this plan are not covered no matter what type of approved category of provider you see.

**The following services are only covered under your In-Plan benefit:**

- All human organ/tissue transplants.
- Temporomandibular joint (TMJ) services.

## How we pay for non-participating provider covered services (UCR)

After you meet your deductible, if any, Providence Health Plan will reimburse payment to non-participating providers for covered services 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.

## Using Your Non-Participating Provider Benefits

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*Example on how UCR charges and your coinsurance for non-participating providers is calculated.*

You see a non-participating provider and you are charged \$100 for an office visit. .... **\$100**  
The UCR charge determined for the service is \$80..... **\$80**  
Your benefit plan has a 20 percent member coinsurance so it pays 80 percent of \$80, not \$100. .... **(80% of \$80 = \$64)**  
Your coinsurance payment for the \$80 is \$16..... **(\$80 - \$64 = \$16)**  
You also may owe the non-participating provider the \$20 difference between the amount the provider charged and the calculated UCR charge. .... **(\$100 - \$80 = \$20)**  
Consequently the total amount you may owe to the non-participating provider would be \$36..... **(\$16 + \$20 = \$36)**

**UCR calculations are complicated and vary by type of service and where the service is received. The best way to get an estimate on what your out-of-pocket costs will be is to talk to your provider before seeing him or her for a specific covered service.**

## Prior Authorization Requirements

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### **Prior authorization services**

Prior authorization services are services which require you and/or your provider to seek Providence Health Plan confirmation before seeking or receiving care. A prior authorization review will determine if the proposed service is medically necessary, and if you or your family members are eligible at the time of the proposed service. If you are seeing a participating provider, your participating provider will work with Providence Health Plan to arrange for any prior authorization requirements that may be required for certain covered services. **If you are seeing a non-participating provider, are responsible for obtaining prior authorization from Providence Health Plan prior to receiving the services listed below. Your non-participating provider may be able to assist you in obtaining prior authorization by contacting the plan on your behalf. If you do not receive prior authorization for services received Out-of-Plan, a 50 percent coinsurance penalty up to \$2,500 for each covered service will be applied.** These penalty amounts do not apply to your out-of-pocket maximums or deductibles.

While prior authorization is a requirement for coverage of some services under this plan, it is not a treatment directive. The actual course of medical treatment that you choose remains strictly a matter between you and your provider. Furthermore, prior authorization is not a guarantee of payment under this plan and it does not supersede other provisions regarding coverage, limitations and exclusions.

### *services that require prior authorization*

**Members are required to get prior authorization from Providence Health Plan for the following services if you receive them from a non-participating provider:**

- 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 must be prior authorized by Providence Health Plan's authorizing agent at 1-800-711-4577. (\*Including autism and other Pervasive Developmental Disorders (PDD). Prior authorization for medical services related to PDD must be submitted to Providence Health Plan at 1-800-638-0449.)
- All human organ/tissue transplant related services
- All restoration of head/facial structures; limited dental services
- All PET, CT, CTA, MRI and MRA imaging and Nuclear Cardiac Study services
- All home health care services
- All hospice services
- All medical supplies, durable medical equipment and prosthetic devices in excess of \$500
- All outpatient hospitalization and anesthesia for covered dental services
- All outpatient cardiac rehabilitation services

## Prior Authorization Requirements

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### *getting services prior authorized*

For all services except non-emergency mental health and chemical dependency services, simply call 1-800-638-0449 to obtain prior authorization.

For mental health and chemical dependency service prior authorization, call Providence Health Plan's authorizing agent at 1-800-711-4577.

When you or your non-participating provider call to request prior authorization, please be prepared to give the following information:

- Member's name.
- Member's health plan identification number and group number (these numbers are listed on your Providence Health Plan member identification card).
- Member's date of birth.
- Provider's name, address and telephone number.
- The name of the hospital or treatment facility.
- Scheduled date of admission, or date services are to begin.
- Treatment or procedure to be performed.

### *plan time frames for responding to prior authorization requests*

**For services that do not involve urgent medical conditions** - We will notify your provider or you of our decision within two business days after we receive the prior authorization request.

**For services that involve urgent medical conditions** - We will notify your provider or you of our decision within 24 hours after we receive the prior authorization request. If we need additional information to complete our review, we will notify the requesting provider or you within 48 hours after we receive the request

### *concurrent care decisions*

If we have approved an ongoing course of treatment for you and we then determine through our medical cost management procedures to reduce or terminate that course of treatment, we will provide advance notice to you of that decision. You may request a 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 after we receive your request.

*For specific appeals information regarding prior authorizations, see "problem resolution - appeals involving prior authorization denials," page 75.*

## Other Requirements for Receiving Covered Services

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### Medically necessary services

Providence Health Plan members are entitled to comprehensive medical care within the standards of good medical practice. Providence Health Plan's medical directors and special committees of participating providers determine which services are medically necessary using these guidelines:

- All medical services that are appropriate and necessary for the diagnosis and treatment of symptoms, illness, disease, injury or condition that is harmful or threatening to your life or health.
- Services that are within the standard of good medical practice within the organized medical community.

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

- Services at the most appropriate level that can safely be provided.

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

- Services that are primarily for your convenience, or the convenience of your provider, hospital or any other health care provider.

*Example: You stay an extra day in the hospital only because the relative who will help you during recovery can't pick you up until the next morning. Providence Health Plan may not pay for the extra day.*

**Although a treatment was prescribed or performed by a qualified health care provider, 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.**

Providence Health Plan has the legal right to determine which medical conditions are covered by your plan, and to what extent the conditions are covered.

### Medical cost management

Coverage under your plan is subject to the medical cost management protocols that are established by Providence Health Plan to ensure the quality and cost effectiveness of covered services. Such protocols may include prior authorization, concurrent review, case management and disease management.

Providence Health Plan reserves the right to deny payment for services that are judged not to meet the criteria maintained by us to determine medical necessity. Following this review, Providence Health Plan will make a decision and notify the member. That decision may be appealed as described under "*problem resolution*," pages 74-76. When there is more than one alternative available, the least costly among medically appropriate alternatives will be approved.

In addition, we reserve the right to make substitutions for the covered services listed in this Member Handbook and your Employer Group Contract. Substituted services must:

- Be medically necessary.
- Have your knowledge and agreement while receiving the service.
- Be prescribed and approved by a qualified practitioner.
- Offer a medical therapeutic value at least equal to the covered service that would otherwise be performed or given.

## Other Requirements for Receiving Covered Services

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Medical treatment information changes and new treatments may become available. Providence Health Plan may stop allowing a substitute service at any time, at our sole option, and we would send a 30-day advanced written notice to you and your qualified practitioner explaining any changes in covered services.

*See “problem resolution: appeals involving prior authorization denials,” page 75, regarding specific appeal procedures for prior authorization requests that are denied by Providence Health Plan.*

### **Approval to release medical information**

When you accept these benefits, you also agree to have your medical records examined by Providence Health Plan under certain specific circumstances. Medical records may be examined for the purpose of utilization review, quality assurance, and peer review by us or our designee. Medical information, such as claims data, may be analyzed for quality improvement purposes. We respect the privacy of our members. Please see “*privacy of member information*,” pages 78-80 for more information.

# Understanding Your Deductibles and Out-of-Pocket Maximums

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*how benefits are applied* Your benefits are subject to the following provisions, if applicable, as stated on your Summary of Benefits:

1. Your deductible
2. Your copayment or coinsurance amount
3. Benefit limits and/or maximums

## **Calendar year deductibles**

The deductible is the dollar amount you are responsible to pay for covered services every calendar year before benefits are provided by Providence Health Plan. Your Open Option plan may have an individual and a family **common deductible**, or it may have an individual and family **Out-of-Plan deductible**.

## *common In-Plan & Out-of-Plan deductibles*

If your plan has a **common deductible**, it will be listed on your Summary of Benefits. **A common deductible applies to both In-Plan and Out-of-Plan benefits.** The deductible can be met by using In-Plan or Out-of-Plan providers, or a combination of both.

## *Out-of-Plan deductibles*

If your plan has an **Out-of-Plan deductible**, it will be listed on your Summary of Benefits. **An Out-of-Plan deductible applies only to your Out-of-Plan benefits.** (You may receive In-Plan benefits without meeting your Out-of-Plan deductible.)

Deductible amounts are payable to your provider after your claim has been processed by Providence Health Plan.

## *waiver of deductible*

Certain covered services may be covered without a deductible. Please see your specific Summary of Benefits for information about these services.

## *individual deductible*

An individual deductible is the amount shown in the Summary of Benefits 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 on your Summary of Benefits, that a family of three (3) or more 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.

**Note:** No member will ever pay more than an individual deductible before we begin paying for covered services for that member.

## *out-of-pocket costs that do not apply to deductibles*

**The following out-of-pocket costs do not apply towards your applicable deductibles:**

- Services not covered by Providence Health Plan.
- 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.

## Understanding Your Deductibles and Out-of-Pocket Maximums

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<b>Calendar year Out-of-pocket maximums</b>	All Open Option plans have both an individual and family annual (calendar year) out-of-pocket maximum. Out-of-pocket maximums are the total amount you or your family will pay out-of-pocket in any calendar year for covered services received under this plan.
<i>individual out-of-pocket maximum</i>	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 Summary of Benefits, before Providence Health Plan begins to pay 100 percent* for covered services for the individual.
<i>family out-of-pocket maximum</i>	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 Summary of Benefits, before Providence Health Plan begins to pay 100 percent* for covered services for the family. The family out-of-pocket maximum applies when there are more than three family members. If three individual family members meet their individual out-of-pocket maximum, the family out-of-pocket maximum will be met and no further individual out-of-pocket maximum will need to be met by any other family members. If the combined copayment and coinsurance expenses of four or more family members meet the family out-of-pocket maximum, all remaining individual out-of-pocket maximums will be waived for the family for that calendar year.  <i>Note:</i> Once any family member meets the individual deductible, Providence Health Plan will begin to pay 100 percent* for covered services for that member.
<i>separate In-Plan &amp; Out-of-Plan maximums</i>	<b>Some Open Option plans have two different sets of per person/per family maximums.</b> If your plan has this type of out-of-pocket maximum, it will be shown on your Summary of Benefits. Separate In-Plan and Out-of-Plan out-of-pocket maximums have one maximum for payments you make for covered services when you use the In-Plan benefit and a separate out-of-pocket maximum for payments you make for covered services when you use the Out-of-Plan benefit. <b>These In-Plan and Out-of-Plan maximums accumulate separately and are not combined.</b>
<i>common In-Plan &amp; Out-of-Plan maximums</i>	<b>Some Open Option plans have a common out-of-pocket maximum.</b> If your plan has this type of out-of-pocket maximum, it will be listed on your Summary of Benefits. The common out-of-pocket maximum combines payments you make for covered services using both In-Plan and Out-of-Plan benefits. You do not need to meet two separate In-Plan and Out-of-Plan annual out-of-pocket maximums.

## Understanding Your Deductibles and Out-of-Pocket Maximums

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*out-of-pocket costs that do not apply to annual out-of-pocket maximums*

**The following out-of-pocket costs do not apply toward your annual out-of-pocket maximums:**

- Services not covered by Providence Health Plan.
- 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 Summary of Benefits as not applicable to the out-of-pocket maximum.
- Durable medical equipment and medical supplies and devices.
- 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:** The above listed covered services not applicable to the out-of-pocket maximum are NOT eligible for 100 percent benefit coverage. The copayment or coinsurance for these services as shown on your Summary of Benefits remains in effect throughout the calendar year.

## Pre-existing Condition Exclusion – Small Employer Plans

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**If your coverage is under a plan issued to a Small Employer, your coverage is subject to a pre-existing condition exclusion.**

**Your Summary of Benefits will show whether or not this exclusion applies to you.**

### **Pre-existing condition exclusion**

A “pre-existing condition” means any medical condition for which medical advice, diagnosis, care or treatment was recommended or received within the six months prior to a member’s enrollment date. For purposes of this pre-existing condition exclusion, “enrollment date” means the *earlier* of the member’s effective date of coverage or any eligibility waiting period that applies to your plan.

The pre-existing condition exclusion **does not apply** to:

- Pregnancy,
- Genetic information without related diagnosis of a medical condition, or
- Covered services for newborns or newly adopted children.

**Coverage for pre-existing conditions is excluded under this plan for a period of six months following the member’s enrollment.**

### ***Creditable Coverage***

Creditable Coverage refers to prior coverage that a family member had under another qualifying health plan. If a member has coverage under another health plan prior to the enrollment date, the 6-month pre-existing condition exclusion period will be reduced so long as:

- The Creditable Coverage is still in effect on the date of the Members enrollment, or
- The Creditable Coverage ended no more than 63 days before the enrollment date under this plan.

## Emergency and Urgent care

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### Definition of an emergency or urgent care situation

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

**The definition of an “Emergency medical condition”** is a medical, psychiatric, mental health and chemical dependency 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 health plan benefits cover emergency services in the emergency room of any hospital in or outside the Providence Health Plan service area. **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.**

### What to do if you have an emergency

If you or a family member believe 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 Providence Health Plan member identification card.

## Emergency and Urgent Care

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### **If you are not sure it's an emergency**

Call your personal physician/provider any time, any day of the week. Your personal physician/provider, or the personal physician/provider on call, will tell you what to do and where to go for the most appropriate care. You also may call Providence RN at 503-574-6520 or 1-800-700-0481, if you're not sure whether to call your personal physician/provider or go to the emergency room. **If you believe that taking time to call your personal physician/provider or Providence RN would threaten your life or cause serious damage to your health, call 911 or go to the nearest emergency room.** *(In accordance with California state law, residents of California cannot use the services provided by Providence RN.)*

### **Emergency care in the service area and outside the service area**

If you are in the Providence Health Plan service area and need emergency services, try to go to the nearest participating hospital. If additional travel time to a participating hospital would endanger your life, go directly to the nearest hospital.

If you are outside the Providence Health Plan service area and need emergency services, go to the nearest hospital.

### **Emergency room copayment**

You are responsible for your plan's copayment/coinsurance whenever you receive services in an emergency room, unless you are admitted to a hospital within 24 hours. Please be prepared to pay your copayment/coinsurance at the time you receive care. You are responsible for your plan's copayment/coinsurance for each hospital emergency room visit. *Please refer to your Summary of Benefits for your copayment/coinsurance amounts and any applicable deductibles.*

### **Services not covered**

Providence Health Plan does not pay for emergency room treatment for medical conditions that are not medical, psychiatric, mental health or chemical dependency 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.

### **Eye emergencies**

If you have an emergency medical condition involving injury or illness to your eye(s), you may receive services directly from an optometrist or ophthalmologist or a hospital emergency room.

### **What to do if you are admitted to a non-participating hospital**

If you are admitted to a non-participating hospital, we must be notified within 48 hours or as soon as reasonably possible. You will need to submit a claim for a non-participating hospital service if the provider does not submit it for you. For information on how to submit a claim, see "*claims administration*," page 61-62.

## Emergency and Urgent Care

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### **Urgent/immediate and after-hours care**

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. You also may call Providence RN at 503-574-6520 or 1-800-700-0481, if you're not sure whether to call your personal physician/provider or go to the urgent care center. *(In accordance with California state law, residents of California cannot use the services provided by Providence RN.)*

Your personal physician/provider or on-call provider 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 copayment/coinsurance usually will be lower. You are responsible for your plan's copayment/coinsurance whenever you receive services in an urgent care clinic, unless you are admitted to a hospital within 24 hours. Please be prepared to pay the copayment/coinsurance at the time you receive care.

If you are admitted to a non-participating hospital, we need to be notified within 48 hours or as soon as reasonably possible.

Providence Health Plan pays for urgent care wherever you are. If you are injured or seriously ill while you are away from our service area, go to any provider or urgent care center.

# Covered Services

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## Introduction

This section lists your covered benefits in a similar order that they appear on your Summary of Benefits. Also, this Member Handbook lists more detailed benefits that might not be listed on your Summary of Benefits. 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 Summary of Benefits 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 (page 3) on our Web site at [www.providence.org/healthplans](http://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.**

For your health care services to be covered using your In-Plan benefits, you must receive the covered services from participating providers. If you use non-participating providers, your Out-of-Plan benefits will apply.

## Physician/provider services

For covered services, we pay the balance in full after you pay your member copayment/coinsurance. For most visits to your personal physician provider, the deductible is waived. On your Summary of Benefits in the *physician/provider services* section, your copayment/coinsurance information is listed for various types of provider visits.

**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 and also would need to pay the laboratory services coinsurance for the throat culture. See your Summary of Benefits for details.

Your Summary of Benefits 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 Summary of Benefits 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.

### *office visits & office surgery*

For covered services, we pay the balance in full after you pay your member copayment/coinsurance. On your Summary of Benefits in the *physician/provider services* section, your copayment/coinsurance information is listed for various types of provider visits.

Your Summary of Benefits also lists different copayments or coinsurance that may apply for other specific services, such as surgery/anesthesia, allergy shots, services for TMJ and maternity care. See your Summary of Benefits 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.

### *inpatient hospital visits*

Provider visits in the hospital for approved hospitalization, including skilled nursing facilities, are covered.

## Covered Services

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### *surgery and anesthesia*

Providence Health Plan will cover provider charges for medically necessary surgery. This may include the fees of a surgeon, an assistant surgeon(s) and an anesthesiologist or registered nurse anesthetist. Your provider and/or Providence Health Plan will arrange and prior authorize your surgery. **(If you are receiving these services from a non-participating provider, you are responsible for making sure the services are prior authorized by us.)**

Some surgical procedures are covered only when performed on an outpatient basis. Your provider and/or Providence Health Plan will tell you in advance if your procedure is an outpatient surgery.

### **Preventive health services**

*(Also please see “wellness benefits,” page 5, for additional benefits.)*

#### *periodic health exams & 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 on your Summary of Benefits.

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.

#### **Recommended guidelines:**

- Well-baby care, up to eight provider office visits during a child’s first 24 months
- For children age 2-6, one exam per year
- For children age 7-19, one exam every two years
- For adults age 20-29, one exam every five years
- For adults age 30-49, one exam every two years
- For adults age 50 and above, 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. Providence Health Plan will not cover this additional fee.

#### *immunizations/ vaccinations*

Benefits for routine immunizations/vaccinations (shots) are covered in accordance with accepted medical practice. Visits to your qualified practitioner’s office or participating pharmacy for immunizations or vaccinations are subject to the copayment or coinsurance shown in the Summary of Benefits.

#### **Covered services do not include:**

Immunizations or vaccinations required 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.

## Covered Services

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### *prostate cancer screening exams*

Benefits for prostate screening examinations include a digital rectal examination and prostate-specific antigen test, biennially for men age 50 and older, or as recommended by your health care provider.

### *colorectal cancer screening exams*

Benefits for colorectal cancer screening examinations for members age 50 and older include:

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

Screening exams or lab tests for high risk members are covered as recommended by your health care provider.

All colonoscopy and sigmoidoscopy services are covered under the Outpatient Surgery benefit stated in the Summary of Benefits. Fecal occult blood tests and double contract barium enemas are covered under Lab Services.

### *members diagnosed with diabetes*

Members diagnosed with either insulin dependent or non-insulin dependent diabetes mellitus, have the following preventive health care benefits:

#### **Regular Exams**

- The following exams are provided annually: Dilated retinal exams by a qualified participating eye care specialist; glycosylated hemoglobin (HbA1c) 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 qualified practitioner.
- Pneumococcal vaccines are provided every five years.
- **NOTE:** With the exception of the dilated retinal exam, all of the above may be performed in your provider's office at the time of your annual exam. The eye exam may be done by an eye care specialist. Exams may be performed more often than once a year if your provider decides they are medically necessary; otherwise, they are treated as preventive exams and covered on that basis.

#### **Diabetes Self-Management Education Program**

Benefits are paid in full for initial self-management education programs. Your provider can recommend a specialist or facility that provides these services. You must be an enrolled member throughout the course of the program for benefits to be paid.

### *nutritional counseling*

A maximum of two nutritional counseling visits per calendar year are covered for weight-loss purposes when medically necessary, as determined by your provider. Fasting and rapid weight loss programs are **not** covered.

As a Providence Health Plan member, you may be able to receive a discount on certain weight management classes. (*Class availability may vary by geographic area. Call Providence Resource Line at 503-574-6595 or 1-800-562-8964 for specific information on classes.*)

## Covered Services

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### **Women's health care services**

Female members may receive women's care exams from their personal physician/provider **or** from any other qualified provider who specializes in women's health care. Women's health care providers include physicians specializing in obstetrics or gynecology, nurse practitioners, certified nurse midwives, or physician assistants specializing in women's health care. **Please note: Women's health care services received from a naturopath or any other alternative care provider are not covered benefits.**

### *annual gynecological exams*

Benefits for annual gynecological examinations include breast, pelvic and Pap examinations once every calendar year, or more frequently if your provider determines that they are necessary.

Benefits also include follow-up exams for any medical conditions discovered during an annual gynecological exam that require additional treatment. Your follow-up visit copayment/coinsurance may differ from your annual gynecological exam copayment/coinsurance. See your plan's Summary of Benefits for details on your copayment/coinsurance information.

### *mammograms*

Annual (calendar year) benefits for mammograms are provided for women over 40 years of age. Mammograms are provided more frequently at the recommendation of your personal physician/provider or women's health care provider.

### *family planning*

Counseling, exams, and services for voluntary family planning are covered.

#### **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 supplementary prescription drug coverage, and are subject to the terms and limitations of the supplementary coverage.

\*IUDs and diaphragms are covered under your medical supply benefit, see page 36.

## Covered Services

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### **Maternity services** *selecting a physician or provider*

Providence Health Plan covers comprehensive maternity care. Women may receive maternity services from their personal physician/provider or from a women's health care provider of their choice.

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.

*(For most employer group plans, there is one copayment per pregnancy for all prenatal, delivery, and postnatal office 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 additional services will apply. Please refer to your Summary of Benefits for details.)*

### *covered services*

- Prenatal care by your physician, provider or certified nurse midwife.
- Birth at an approved facility.
- Postnatal care, including complications of pregnancy and birth.
- Newborn nursery care, as shown in the Summary of Benefits, is covered only when a newborn child is properly enrolled within timeframes stated under "eligibility," page 7. Please see page 7 for more details.
- Emergency treatment for complications of pregnancy and unexpected pre-term birth outside the service area.

**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 following services are not covered:**

- Home births.
- Services of a lay midwife.

### *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](http://www.providence.org/classes) for information on classes, specific dates, locations, registration and prices. Classes vary by geographic area. See "health education," page 5, for additional information. 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.

## Covered Services

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### Hospital services

Hospital services are covered, as stated on your Summary of Benefits. A copayment or deductible, if applicable, will be applied once for a continuous period of hospitalization, 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:**

- Room and board and supervisory or custodial services.
- Personal hygiene and other forms of self-care.
- 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:**

- Private duty nursing or a private room unless prescribed as medically necessary.
- Take-home medications, supplies and equipment.
- Personal items such as telephone, radio, television and guest meals.

### *inpatient acute care*

**Using participating providers:** When your provider and Providence Health Plan determine you need hospitalization, arrangements will be made for you to be admitted to a participating hospital.

**For members using the Out-of-Plan benefit:** You are responsible for making sure inpatient hospitalization services are prior authorized by us before receiving 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.

## Covered Services

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### *inpatient rehabilitative care*

**Generally, covered inpatient rehabilitative care is limited to 30 days per calendar year or as stated on your Summary of Benefits.** Benefits are provided for physical, occupational and speech therapy. Benefits apply when you need a full rehabilitation team approach and the services can be provided to you only as an inpatient. These services must be part of your provider's treatment program to improve lost function after an illness or an injury. If you are 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 significant improvement of a member's condition.

When receiving this care from a non-participating provider, you are responsible for making sure inpatient rehabilitative care services are prior authorized by Providence Health Plan.

### *skilled nursing facility*

**Generally, covered skilled nursing facility services are limited to 60 days per calendar year or as stated on your Summary of Benefits.** Skilled nursing facility services are covered when 24-hour skilled or subacute care is required and cannot adequately be provided through a home health program. Only medically necessary services are covered. Providence Health Plan may determine that your care needs are better served by transferring you from the hospital to a skilled nursing facility and reserves the right to make such a transfer. Services must be prescribed by your provider and prior authorized by us.

When receiving this care from a non-participating provider, you are responsible for making sure inpatient rehabilitative care services are prior authorized by Providence Health Plan.

## Covered Services

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### **Mental health & chemical dependency**

Mental health and chemical dependency services are covered 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.

#### *arranging mental health or chemical dependency service*

Outpatient mental health and chemical dependency office visits can be arranged by contacting your provider's office. No prior-authorization is required. If you need further assistance finding a participating provider, visit our Online Participating Provider Directory at [www.providence.org/healthplans](http://www.providence.org/healthplans).

*Non-emergency* inpatient, residential, and day treatment mental health\* and chemical dependency services are covered benefits only when prior authorized. Please contact Providence Health Plan's authorizing agent at 1-800-711-4577. Providence Health Plan's authorizing agent and your qualified practitioner will coordinate your care. (\*Including autism and other Pervasive Developmental Disorders (PDD). Prior authorization for medical services related to PDD must be submitted to Providence Health Plan at 1-800-638-0449.)

For *emergency* mental health or chemical dependency services, go directly to a hospital emergency room. You do not need prior authorization for emergency treatment. We must be notified within 48 hours of emergency treatment, or as soon as reasonably possible.

#### *mental health services*

Benefits include medically necessary covered services for the diagnosis and treatment of mental health conditions.

#### **Covered services include:**

- Outpatient diagnostic evaluation and mental health treatment including individual and group therapy.
- Inpatient, residential and day or partial hospitalization for the treatment of mental disorders. These services must be obtained at a treatment facility approved by Providence Health Plan or its authorizing agent.

#### *chemical dependency services*

Benefits include medically necessary covered services for the diagnosis and treatment of chemical dependency (drug and alcohol treatment), including detoxification if enrolled in a chemical dependency treatment program. Treatment involving the use of methadone is covered only when such treatment is part of a medically supervised treatment program approved by Providence Health Plan or its authorizing agent.

#### **Covered services include:**

- Outpatient diagnosis and treatment for chemical dependency including, detoxification. Treatment includes individual and group therapy.
- Inpatient, residential and day or partial hospitalization for the treatment of chemical dependency disorders. These services must be obtained at a treatment facility approved by Providence Health Plan or its authorizing agent.

## Covered Services

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*medically necessary  
detoxification*

Medically necessary detoxification will be treated as an emergency medical condition when members are not enrolled in other chemical dependency treatment programs at the time services are received. Members do not need prior authorization for this emergency treatment; however, Providence Health Plan's 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 our authorizing agent.

### **Emergent/urgent & ambulance services**

*emergency services*

Please see "*emergency and urgent care*," pages 23-25.

*urgent care services*

Please see "*emergency and urgent care*," pages 23-25.

*ambulance*

Benefits include services for emergency medical transportation by state certified ambulance services and certified air ambulance transportation when medically necessary.

Out-of-area ambulance services are covered to provide transportation to the nearest facility, or to a facility specified by Providence Health Plan.

**We do not cover care cars, other medical transportation vehicles and other non-emergency medical transportation.**

## Covered Services

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### **Medical and diabetes supplies, durable medical equipment, appliances, prosthetic devices**

Providence Health Plan will provide coverage for the purchase or rental of approved medical supplies/devices, prosthetic devices and durable medical equipment (DME) that we approve for our members. All supplies, equipment and devices must be required for the standard treatment of the illness or injury.

All Providence Health Plan-approved supplies, equipment and devices must be medically necessary and are limited to the most cost-effective equipment. 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. All supplies, equipment and devices must be prescribed by your qualified practitioner.

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 the we determines 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.

#### **Participating Medical Supply/Equipment Providers – (In-Plan benefit only)**

Providence Home Health coordinates all home medical equipment covered by Providence Health Plan through its home services network. In most instances home health equipment purchases will be coordinated with Providence Home Health by your participating provider. If you need to purchase home medical equipment on your own, you must call Providence Home Health at 1-800-531-9754.

#### **Exceptions:**

- Some covered equipment, supplies and appliances dispensed during an office or hospital visit can still be billed by your provider directly to Providence Health Plan without going through Providence Home Health.
- You can purchase diabetes supplies through participating pharmacies and other participating vendors who sell these supplies rather than buying them through Providence Home Health.

#### **Non-Participating Medical Supply/Equipment Providers – (Out-of-Plan benefit only).**

All medical supplies, durable medical equipment, appliances and devices over \$500 must be prior authorized by Providence Health Plan. *Please see “prior authorization requirements” pages 15-16.*

#### **Providence Health Plan covers:**

- **Casts, braces and supportive devices** – Covered when used in the treatment of medical or surgical conditions in acute or convalescent stages or as immediate post-surgical care.
- **Initial and replacement contact lenses, intraocular lenses, prescription lenses or standard frame glasses** – Covered 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.
- **Rental of oxygen units used in the home** – Covered 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.

## Covered Services

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- **Removable custom shoe orthotics** – Covered when required as a result of surgery, congenital defect or diabetes. Limits are as stated on your Summary of Benefits
  - **Prosthetic devices** – Covered supplies include prosthetic devices such as artificial limbs, breast implants following mastectomy, and artificial eyes.
  - **Maxillofacial prosthetic devices** – Covered when considered medically necessary for the restoration and management of head and facial structures that cannot be replaced by living tissue. When head and facial structures are impaired due to disease, trauma, or developmental deformity. The devices must be needed to control or eliminate infection and pain and restore facial configuration and function.
  - **Diabetes supplies** - Blood sugar test strips are covered, but limited to 100 strips per month for members with insulin dependent diabetes and 100 strips every three months for members with non-insulin dependent diabetes unless otherwise prescribed by your treating provider. You can purchase diabetes supplies through participating pharmacies and other participating vendors who sell these supplies rather than buying them through Providence Home Health.
  - **Medical devices surgically implanted in a body cavity to replace or aid the function of an internal organ.**
  - **Medically necessary medical foods** – Covered 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. Approval of these services will be based on criteria established by Providence Health Plan and in accordance with regulatory requirements. Medical foods are defined as foods that are formulated to be consumed or administered enterally under strict medical supervision for the treatment of inborn errors of metabolism including, but not limited to: phenylketonuria (PKU); homocystinuria, citrullinemia, maple syrup disease; and pyruvate dehydrogenase deficiency. Medical foods do not include total parenteral nutrition (TPN), as this is covered under “*allergy shots, serums, and injectable medications,*” page 37.
  - **Other medically necessary supplies** – Covered when ordered by a qualified practitioner, including, but not limited to, ostomy supplies, IUDs, prescribed needles, and syringes. Non-sterile examination gloves used by you or your caregiver are not a covered medical supply.
  - **Durable medical equipment (DME)** – Covered for rental of crutches, non-motorized wheelchairs, hospital beds, or other therapeutic equipment when prescribed by a qualified practitioner, subject to our durable medical equipment definition. 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).
- No other medical supplies, devices, prosthetic devices or DME are covered.**

## Covered Services

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### Other covered services

*allergy shots, serums  
and injectable medications*

Allergy shots, serums, injectable medications and total parenteral nutrition (TPN) are covered as shown on your Summary of Benefits. 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.

*diagnostic x-ray and  
laboratory services*

Providence Health Plan pays for inpatient and outpatient diagnostic pathology (laboratory), imaging services (such as PET, CT, MRI), radiology (x-ray) tests, required contrast materials (dyes) and other medically necessary diagnostic procedures when ordered by a qualified provider.

*inborn errors of metabolism*

Covered services include services received for diagnosing, monitoring and controlling inborn errors of metabolism, including PKU, that involve amino acid, carbohydrate and fat metabolism. Covered services include clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. See “*medically necessary medical foods*,” page 36, for coverage information on medical food supplies. Coverage is provided as shown on your Summary of Benefits based upon the type of services received.

*podiatry/foot services*

Covered services include the services provided by a podiatrist or other qualified practitioner and are covered as stated on your Summary of Benefits under the Physician/Provider Services section. Covered services include, but are not limited to, the fitting and follow-up exam for removable custom orthotics when required as a result of surgery, congenital defect or diabetes. Removable custom shoe orthotics are covered as stated under “*Removable custom shoe orthotics*,” page 36.

**Covered services do not include routine foot care and the removal of corns or calluses, unless you have diabetes.**

*reconstructive surgery  
of the breast*

Reconstructive breast surgery of the breast following a mastectomy is a covered benefit and is subject to the same deductibles and coinsurances applicable to other medical and surgical benefits covered under this plan and are as stated in your Summary of Benefits. This includes reconstruction of the involved breast following a mastectomy due to disease, illness or injury; surgery and construction of the other breast to produce a symmetrical appearance; and prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

*reconstructive  
surgery*

Reconstructive surgery is covered for conditions resulting from trauma, infection or other diseases and for congenital deformities or anomalies if there is a resultant functional impairment. Benefits are covered as those services listed on your Summary of Benefits based upon the type of services received.

## Covered Services

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### *short-term outpatient rehabilitative services*

Generally, **short-term outpatient rehabilitative services are covered up to 30 visits per calendar year, or as stated on your Summary of Benefits.** Short-term outpatient physical, occupational and speech therapy is provided by physicians and/or licensed or registered therapists to restore or improve function following an illness or injury. Benefits are limited to covered services that can be expected to result in the measurable improvement of your condition. The treatment must be part of a written treatment plan prescribed by a qualified provider.

**IMPORTANT NOTE:** A visit is considered a treatment with one provider. For example, if you see a physical therapist and a speech therapist in 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:**

- Adjustments and manipulations of any spinal or bodily area;
- Exercise programs;
- Rolfing, polarity therapy and similar therapies; and
- Growth and cognitive therapies, including sensory integration.

### *outpatient surgery, dialysis, infusion, chemotherapy & radiation therapy*

Benefits are provided as shown on your Summary of Benefits and include outpatient services at a hospital or other outpatient surgical facility.

Covered services include, but are not limited to, dialysis, services for a surgical procedure, outpatient cardiac rehabilitation and regularly scheduled therapy such as infusion, chemotherapy, inhalation therapy, or radiation therapy as ordered by a qualified practitioner. Providence Health Plan 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 and you will be fully responsible for payment.

If you do not obtain prior authorization from Providence Health Plan for the services listed above, you will be responsible for any penalties you may have to pay, as stated under “*prior authorization requirements*,” pages 15-16.

### *self-administered chemotherapy*

Benefits are provided for self-administered chemotherapy agents, including oral medications, topicals, and injectable medications, when received from a participating retail or specialty pharmacy as shown in the Summary of Benefits. If your plan includes supplemental prescription drug coverage, self-administered chemotherapy is covered as indicated on your Prescription Drug Summary of Benefits when that coverage results in a lower out-of-pocket cost to you.

## Covered Services

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### *restoration of head, facial structures and 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 impaired because of trauma, disease or birth or development deformities. Benefits are covered as those services listed on your Summary of Benefits based upon the type of services received.

#### **Covered services do not 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.
- Services to treat TMJ joint disorder, except as specified in the covered TMJ services section below.

### *temporomandibular joint (TMJ) services*

Benefits are provided for TMJ services from a participating provider as shown on your Summary of Benefits.

#### **Covered services for TMJ include:**

- A diagnostic examination including a history, physical examination and range of motion measurements as necessary.
- Diagnostic x-rays.
- Physical therapy of necessary frequency and duration.
- Therapeutic injections.
- Therapy utilizing an appliance/splint that 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. The benefit for the appliance/splint therapy will include an allowance for diagnostic services, office visits and adjustments. Appliances/splints are covered under the TMJ benefit, not the Durable Medical Equipment (DME) benefit.
- Surgical services.

#### **Benefit limitations and exclusions for TMJ services:**

- \$1,000 per calendar year/\$5,000 maximum per lifetime, per member, or as stated on your Summary of Benefits.
- Covered services do **not** include dental or orthodontia services.
- Out-of-Plan benefits do **not** apply to TMJ services.

### *outpatient hospitalization and anesthesia for dental services*

Benefits for outpatient hospitalization and anesthesia for dental services are covered the same as relevant services listed on your Summary of Benefits. Services are only 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 that cannot be managed safely and efficiently in a dental office.

**All other dental services are excluded.**

## Covered Services

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### *home health care*

Home health visits are covered as shown on your Summary of Benefits. Rehabilitation services provided under an authorized home health care plan will be covered as home health care services. To be a covered benefit, a home health care provider must provide services at your home under a home health care treatment plan. Each visit by a person providing services under a home health care treatment plan, or each visit to evaluate the need for or development of a plan, is considered to be one home health care visit. Up to four consecutive hours in a 24-hour period of home health care service is considered to be 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.

#### **For home health care to be a covered benefit:**

- Your qualified provider needs to certify 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; and the home health care services must be prior authorized by Providence Health Plan.
- If you were hospitalized immediately prior to the start of your home health care, the home health plan must be initially approved by the same qualified practitioner who was the primary provider of the services you received during your hospitalization.

#### **Home health care benefits do not include:**

- Charges for mileage or travel time to and from your home.
- Wage or shift differentials for home health providers.
- Charges for supervision of home health providers.
- Services that consist principally of custodial care including, but not limited to, care for senile deterioration, mental deficiency, developmental disability, mental illness, or care of a chronic or congenital condition on a long-term basis.
- Services provided that are not otherwise covered by Providence Health Plan.

## Covered Services

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*hospice care* Covered hospice care services are provided, as stated on your Summary of Benefits, for members who have a terminal illness and are expected to live six months or less. This determination needs to be certified by your qualified provider and determined to be medically necessary and prior authorized by Providence Health Plan. Covered services provided must be 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 that a certified hospice care program is required to include.

**Covered services include:**

- Nursing care provided by or under the supervision of a registered nurse.
- 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 the patient and caregivers adjust to the approaching death.
- Services provided by your qualified practitioner or a physician associated with the hospice program
- 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.
- Home health aide services for personal care, maintenance of a safe and healthy environment and general support for the goals of the plan of care; including a maximum of 120 hours of respite care to the primary care giver during a three-month period.
- Rehabilitation therapies provided for purposes of symptom control or to enable the patient to maintain activities of daily living and basic functional skills.
- Continuous home care during a period of crisis in which the patient requires skilled intervention to achieve palliation or management of acute medical symptoms.
- Benefits for hospice care services may be extended an additional six months in cases where a member is facing imminent death, or is entering a remission, and the member's condition has been certified in writing by the attending physician.

**Extended respite care and other services not listed above are excluded from the hospice care benefit.**

## Covered Services

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### *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 Providence Health Plan member); or
- Removed from and replaced in the same person's body (a self-donor who is a Providence Health Plan member).

The term *transplant* does not include services for replacement of a cornea or services related to the transfusion of blood or blood derivatives (except hematopoietic stem cells). These services are considered to be general services and covered the same as other general services listed under physician/provider or hospital services. See "*physician/provider services*," pages 26-27 and "*hospital services*," pages 31-32, for general service coverage information.

#### **Covered services for transplants are limited to services that:**

- Are prior authorized and determined by Providence Health Plan to be medically necessary and medically appropriate according to national standards of care;
- Are provided at a facility approved by or under contract with Providence Health Plan (**out-of-plan benefits do not apply to transplant services**);
- 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
- 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. Coverage is provided as shown on your Summary of Benefits based upon the type of services received.

Travel expenses are subject to a \$5,000 benefit maximum for transportation, food and lodging and also apply to the \$250,000 transplant benefit maximum. Food and lodging is subject to a \$150 per diem and apply to the \$5,000 travel expenses benefit maximum. (Note: Travel services are not covered for donors.)

## Covered Services

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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:

- Initial evaluation of the donor and related program administration costs;
- Preserving the organ or tissue;
- Transporting the organ or tissue to the transplant site;
- Acquisition charges for cadaver or live donor;
- Services required to remove the organ or tissue from the donor; and
- 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.

**Transplant maximums:** Unless stated otherwise on your plan's Summary of Benefits, the following maximum benefits will apply for human organ/tissue transplant services:

- Lifetime maximum for all services (recipient, donor and self-donation) is \$250,000. If your employer group plan has a prescription drug supplemental benefit, benefits for outpatient medications do not apply toward the lifetime maximum. See "*outpatient medications*" section below.

**Transplant facility services provided to the recipient:** Applicable benefit plan deductible, and coinsurance/copayment amounts are waived for transplant facility services. However, the recipient is responsible for any other coinsurance/copayment amounts for inpatient hospital services, as shown on your plan's Summary of Benefits. Any coinsurance/copayments you pay will apply to the recipient's out-of-pocket maximum.

**Outpatient medications:** Benefits for outpatient medications and anti-rejection (immunosuppressive) drugs are provided **only** if your employer group plan includes a prescription drug supplemental benefit. Such coverage, if any, is separate from the provisions of this section and is not subject to any applicable lifetime maximum benefits for human organ/tissue transplants as stated above.

**Physician/Provider services:** Benefits for physician/provider services are provided as shown on your Summary of Benefits. You are responsible for the coinsurance/copayment amounts for those services, as shown in the Summary of Benefits, and those amounts will apply to your out-of-pocket maximum.

**Prior authorization:** To qualify for coverage from Providence Health Plan, all transplant related services, procedures, treatment protocols and facilities must be prior authorized, including initial consultation; evaluation; transplant facilities; donor evaluation; donor services; HLA typing; travel expenses; pre-transplant care; self-donation services; transplant services; and follow-up treatment.

**Note: Prior authorization is not a treatment directive. The actual course of medical treatment that you choose remains strictly a matter between you and your physician and is separate from Providence Health Plan's prior authorization requirements.**

## Covered Services

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### **The following exclusions apply to human organ/tissue transplants:**

- Any transplant procedure that has not been prior authorized by Providence Health Plan;
- Any transplant procedure performed at a transplant facility that has not been approved by Providence Health Plan;
- Any transplant deemed to be experimental or investigational as determined by Providence Health Plan;
- Services or supplies for any transplant that are not specified as covered services, such as transplantation of animal organs or artificial organs;
- Outpatient medications and anti-rejection (immunosuppressive) drugs, unless your employer group plan includes a supplemental prescription drug benefit;
- High-dose chemotherapy administered prior to a transplant, unless those services have been prior authorized by Providence Health Plan;
- 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 Providence Health Plan; and
- Transplant-related travel expenses for the donor and the donor's and recipient's family members.

**Human organ/tissue transplant exclusion period:** No benefits for human organ/tissue transplants will be payable during the first 24 months you are covered by Providence Health Plan.

This exclusion period does **not** apply to:

- Newborn or adopted children who are eligible for coverage under your benefit plan. *For more information on coverage eligibility, please see "newly acquired dependents," page 7.*
- Members who have applicable Creditable Coverage. Providence Health Plan will reduce the duration of the 24-month exclusion period by the amount of prior Creditable Coverage if the most recent period of Creditable Coverage ended within 63 days of the effective date of coverage under your benefit plan. However, if benefits for human organ and tissue transplant covered services would not have been payable under the previous coverage for any reason, no credits will be given toward the 24-month exclusion period under this plan. You are responsible for furnishing proof of Creditable Coverage and evidence of the terms of human organ and tissue transplant covered services under the previous coverage. *For more information on Creditable Coverage, please see "Certificate of Creditable Coverage," page 67.*

# Exclusions

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In addition to those services listed as not covered in the “*emergency and urgent care*” and the “*covered services*” section, pages 23-44, the following are **not covered**.

**IMPORTANT NOTE:** *These exclusions are specific to your Open Option Summary of Benefits. Your employer may have purchased supplemental benefits offering some of the services excluded below. If this is the case, a separate Summary of Benefits for each of your Supplemental Benefits will be included in your member materials. See pages 50-60 for more information regarding Supplemental Benefits.*

## General exclusions:

- Services that are **not provided**.
- Services provided without charge or for which **you would not be required to pay if you did not have this coverage**.
- Services received **before your effective date of coverage**.
- Services that are **not a covered service** or relate to complications resulting from a non-covered service.
- Services that are **not furnished by a qualified practitioner** or qualified treatment facility.
- Services 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.
- Services 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.
- Services provided while you are in the custody of any law enforcement authorities or while incarcerated.
- Services, 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).
- Services 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.
- Services performed in **association with a service that is not covered** by Providence Health Plan.
- Services provided for any injury or illness 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. 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.
- Services that are payable under any **automobile medical, personal injury protection (“PIP”), 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 plan that are subject to this exclusion are provided solely to assist you and such assistance does not waive Providence Health Plan’s right to reimbursement or subrogation as specified under “*third-party liability*,” page 65. This exclusion also applies to services and supplies after you have received proceeds from a settlement as specified in the “*benefits from other sources*” section, pages 65-66.
- Services provided in an **institution that specializes in treatment of developmental disabilities**.
- Services provided for treatment or testing required by a **third party** or court of law which are not medically necessary.
- Services that are **experimental/investigational**.
- Services that are determined by Providence Health Plan **not to be medically necessary** for diagnosis and treatment of an injury or illness.

## Exclusions

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- Service that 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 that 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 that member is convicted for the conduct. This does not 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).
- Services that are determined to be caused by 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.
- Services and supplies received by a member under the **Oregon Death with Dignity Act**.

### **Exclusions that apply to mental health and chemical dependency services:**

- Services for conditions that are **not responsive to therapeutic management** after a diagnosis is made by a physician who has treated or examined the patient, except when the treatment or services provided are effective in maintaining existing functionality or preventing a decline in functionality.
- Services for conditions that are specified as excluded in the explanation of **mental health and chemical dependency, pages 33-34**.
- Services provided under a **court order or as a condition of parole or probation or instead of incarceration** which are not medically necessary.
- Services for **personal growth**, 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 to household items and expenses; services to improve economic stability, and interpretation services.
- Evaluation or treatment services for **education, professional training, employment investigations, and fitness for duty**.
- Services provided by **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 developmental disability and motor skill disorders, and educational speech delay including delayed language development, except as stated under “*inpatient rehabilitative services*,” page 32 and “*short-term outpatient rehabilitative services*,” page 38.
- **Counseling services 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 under “*prior authorization requirements*,” pages 15-16.
- Services related to the treatment of **sexual disorders, dysfunctions or addiction**.
- **Vocational, pastoral or spiritual counseling services**.
- **Dance, poetry, music or art therapy services**, except as part of an approved treatment program.
- Services and treatments that **do not meet the national standards for mental health/chemical dependency professional practice**.
- More than one (1) **long-term residential Mental Health program**, lasting a maximum of forty-five (45) days, within a calendar year.

# Exclusions

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## Exclusions that apply to provider services:

- Services of licensed **acupuncturists**, a physician performing acupuncture services, **naturopathic** physicians and **chiropractic** physicians.
- Services of **homeopaths**, faith healers, or lay midwives.

## Exclusions that apply to reproductive services:

- All services related to **sexual disorders or dysfunctions** regardless of gender, 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 miscarriages (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.
- **Home births** and all related services.
- 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 keratomelelusion 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 and vision care**, vision exams/screenings, refractive disorders, eyeglass frames and lenses, contact lenses.
- **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.
- Hearing screenings and exams.

## 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), except as approved by Providence Health Plan and described under “*restoration of head, facial structures and limited dental services,*” page 39.
- Services for **temporomandibular joint syndrome** (TMJ) except as described under “*temporomandibular joint (TMJ) services,*” page 39.
- Services for **orthognathic surgery**, except as approved by Providence Health Plan and described under “*restoration of head, facial structures and limited dental services,*” page 39.
- **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.
- Services for **insoles, arch supports**, heel wedges, lifts and orthopedic shoes. Covered services for removable custom shoe orthotics are described under “*Removable custom shoe orthotics,*” page 36.

# Exclusions

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## Exclusions which apply to prescription drugs, medicines and devices:

- Outpatient prescription drugs, medicines and devices except as covered under the self-administered chemotherapy benefit or any supplemental prescription drug benefit your employer group may have purchased.
- 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.

## Exclusions that apply to miscellaneous services and items:

- Charges in excess of the **usual, customary and reasonable (UCR)** charge as defined by Providence Health Plan.
- **Custodial care.**
- **Transplants**, except as described under “*human organ/tissue transplants*,” pages 42.
- Services for **durable medical equipment (DME)**, medical supplies/devices and prosthetic devices except as described under “*medical and diabetes supplies, durable medical equipment, appliances, prosthetic devices*,” pages 35-36.
- 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 described under “*inpatient rehabilitation care*,” page 32, and “*short-term outpatient rehabilitative services*,” page 38.
- “**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 treatment sessions by computer Internet service.
- **Missed appointments.**
- **Non-emergency medical transportation.**
- **Allergy shots and allergy serums** except as stated under “*allergy shots, serums and injectable medications*,” page 37.
- All services and supplies related to the **treatment of obesity** or morbid obesity, other than nutritional counseling as described under “*nutritional counseling*,” page 28.
- Services for **dietary therapy**, other than nutritional counseling as described under “*nutritional counseling*,” page 28.
- **Transportation** or travel time, food, lodging accommodations and communication expenses, except as described under “*covered services*,” pages, 26-44, and with Providence Health Plan’s 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, except when prescribed as part of a nutrition therapy plan for the treatment of diabetes.
- Services for **genetic testing**, 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 as **Extra Values and Discounts**, where available, or as covered under an endorsement to this Group Contract;

## Exclusions

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- **Cosmetic services** including supplies and drugs, except as approved by Providence Health Plan and described under “*reconstructive surgery*,” page 37.
- Services (including **routine physical examinations**, 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.
- **Air ambulance transportation** for non-emergency situations, unless approved by us in advance.

# Supplemental Benefits

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## Introduction

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 (e.g., 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 Summary of Benefits for each supplemental benefit.

## 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 subject to your plans benefits, limitations and exclusions.

### *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. Pharmacies are designated as participating retail, preferred retail, specialty and mail order pharmacies. To view a list of our participating pharmacies visit our Web site at **[www.providence.org/healthplans](http://www.providence.org/healthplans)**. You also may contact your Customer Service team at the telephone number listed on your member identification card.

- Please present your member identification card to the participating pharmacy at the time you request services. If you have misplaced or do not have your member identification 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 Summary of Benefits.
- Copayments, coinsurance and any difference in cost for prescription drug covered services *do not* apply to your annual medical out-of-pocket deductibles or out-of-pocket maximums.
- Pharmacy benefits used under your Prescription Drug Supplemental Benefit *do* apply to your Lifetime Maximum Benefit listed on our Open Option Summary of Benefits.
- Participating pharmacies may not charge you more than your copayment or coinsurance. Please contact your Customer Service team 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.

## Supplemental Benefits

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- You may purchase up to a 90-day supply of each maintenance drug 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 identification number to one of our participating mail order pharmacies. To find our participating mail-order pharmacies, please visit our Web site at [www.providence.org/healthplans](http://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 Open Option plan's medical supplies and devices benefits, limitations and copayments and/or coinsurances.
- Insulin is covered by the Plan. Once you've received insulin for the first time with a prescription, you will not need another prescription to obtain insulin thereafter.
- Self-administered chemotherapy drugs are covered under your Open Option plan unless the benefits under this Supplemental Prescription Drug Benefit allow for a lower out-of-pocket cost to you.

### *use of non-participating pharmacies*

On rare occasions, such as urgent or emergency situations, you may need to use a nonparticipating 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 online at our Web site or by contacting your Customer Service team.

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.

## Supplemental Benefits

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***prescription drug formulary***

The Providence 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.

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.

Our formulary is updated regularly throughout the year and qualified practitioners are encouraged to submit suggestions for additions to us. You may obtain a copy of the formulary from our Web site or by contacting your Customer Service team.

***generic and brand name prescription drugs***

Both generic and brand names drugs are covered benefits subject to the terms of your medical Summary of Benefits. In general, generic drugs are subjected to lower copayments or coinsurances than brand name drugs. Please refer to your medical Summary of Benefits for your copayment or coinsurance information.

If you request a brand name drug, or if your provider prescribes a brand name drug when a generic is available, you will be responsible for the difference in cost between the brand name and generic drug, in addition to your brand name drug copayment. 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 on the Value-Based Supplemental Prescription Drug Summary or Benefits.

***prescription 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.

***participating mail-order pharmacy***

Prescribed maintenance drugs (drugs are those you have been on for at least 30 days and that you anticipate continuing on in the future) purchased from a participating mail-order pharmacy will be covered subject to the following specific provisions:

1. Qualified drugs under this program will be determined by the Plan. Not all prescription drugs are available through mail-order pharmacy.
2. Copayment(s) will be applied to the quantity stated on your medical Summary of Benefits. (Some quantity limitations and copayments for unit of use packaging may apply).

Payment is required prior to processing your order. If there is a change in our participating mail-service pharmacies, you will be notified of the change at least 30 days in advance.

## Supplemental Benefits

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### *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 Summary of Benefits. 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 percent 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 Open 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.

### *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 or number of doses. 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, the 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 your Customer Service team;
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). For a copy of our Specialty Medications list, visit our Web site at [www.providence.org/healthplans](http://www.providence.org/healthplans), or contact your Customer Service team.
4. Self-injectable medications are only covered if they are intended for self-administration; labeled by the FDA for self administration; and on our list of "Specialty Medications."
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; and
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 are not covered.

## Supplemental Benefits

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### *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;
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 by state or local law;

## Supplemental Benefits

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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. (Providence Health Plan provides access to discounted smoking cessation programs, including drug therapy. In addition, approved smoking cessation programs including drug therapy may be available under your medical benefit);
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; and
26. Drugs that are not FDA approved or are designated as “less than effective” by the FDA (also known as “DESI” drugs).

***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.

## Supplemental Benefits

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### **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 Summary of Benefits and in this section.

#### *alternative care providers*

All Members, except Alternative Care Plus\* and Traditional Option\* 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 Web site at [www.providence.org/healthplans](http://www.providence.org/healthplans) or call your Customer Service team.

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 us, and we will either locate a provider for you or we will authorize your use of a non-participating provider.

You will need to pay the non-participating provider directly for the care you receive, and then submit your itemized billing statement to us for reimbursement. Please include an explanation of why you received care from a non-participating provider along with your itemized billing statement. 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 and Traditional Option 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.

#### *acupuncturists*

##### **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.

## Supplemental Benefits

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- chiropractors* **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 for 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
- naturopathic physicians* 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.
  - c. 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.
  - 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.

## Supplemental Benefits

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**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** tolerancy test

*general exclusions to  
all 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
- 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 services
- Non-emergency transportation services, including care cars or other transportation vehicles (emergency transportation is covered as stated in your Medical Transportation benefit)
- 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 on the Alternative Care Supplemental Summary of Benefits
- Services received from non-participating providers, except as discussed in this section (*does not apply to Alternative Care Plus or Traditional Option members*).

## Supplemental Benefits

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### 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 Summary of Benefits and in this section.

#### *chiropractic care providers*

All members, except Traditional Option\* members, must receive covered services from our nationwide network of participating chiropractors. To find a chiropractic care participating provider in your area, visit our Web site at [www.providence.org/healthplans](http://www.providence.org/healthplans) or call your Customer Service team.

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 chiropractor in your area. If this happens, please contact us, and we will either locate a provider for you or we will authorize your use of a non-participating provider.

You will need to pay the non-participating provider directly for the care you receive, and then submit your itemized billing statement to us for reimbursement. Please include an explanation of why you received care from a non-participating provider along with your itemized billing statement. 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.

\*Traditional Option members may access services from any qualified chiropractor. Providers must be licensed in the state in which they are practicing and must practice within the scope of their license.

#### *chiropractic covered 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 for neuromusculoskeletal disorders
- Related diagnostic x-rays and laboratory services

#### *exclusions to chiropractic 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
- Services received from a chiropractor that are not listed as a covered service
- Hypnotherapy, behavior training, sleep therapy and weight programs

## Supplemental Benefits

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- 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
- 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 on the Chiropractic Care Supplemental Summary of Benefits
- Services received from non-participating providers, except as discussed in this section (*does not apply to Traditional Option members*).

### **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 Summary of Benefits.

All supplemental vision care benefits are subject to the provisions listed in your Vision Care Supplemental Summary of Benefits. Please review this document before accessing vision services.

If you have questions regarding your supplemental vision care benefit, please contact your Customer Service team.

### **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 Summary of Benefits.

All supplemental elective sterilization benefits are subject to the provisions listed in your Elective Sterilization Supplemental Summary of Benefits. 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 your Customer Service team.

# Claims Administration

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**Introduction** 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 Providence Health Plan.

**Submitting a claim** All participating providers and many non-participating providers will bill Providence Health Plan for you. You may receive a bill for information purposes only, stating “Your insurance has been billed.”

In order to ensure the timely processing of claims, you are encouraged to submit a claim for treatment within 60 days of the date of service. Providence Health Plan will not pay claims received more than 365 days after the date of service. However, exceptions will be made if we receive documentation of your legal incapacitation. Providence Health Plan will pay a covered expense to the provider, the member, or jointly to both. You may submit claims to:

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

If Providence Health Plan mistakenly makes a payment to which a member is not entitled, we may recover the payment through appropriate means. 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.

**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.

**Timeframes 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.

**Claims payment** Our payments for most services are made directly to the providers of services. If you are billed directly and pay for benefits which are covered by this plan, reimbursement will be made only upon your written notice to us of the payment. Payment will be made to the member, subject to written notice of claim, or, if deceased, to the member’s estate, unless payment to other parties is authorized in writing by you.

## Claims Administration

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*right of recovery* Providence Health Plan has the right, upon demand, to recover from a recipient the value of any benefit or claim payment that exceeded the benefits available under the member's benefit plan. This 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 Providence Health Plan under any contract.

*getting medical claims processed* If you are covered by more than one health plan, you will want to ensure that all plans that provide your health care coverage are billed for the services you receive. Check with your physician or other health care provider's office staff to find out if they will bill your secondary carrier, or if you will need to forward a copy of the bill yourself.

Most health plans will send you an explanation of benefits (EOB) whenever a medical claim is processed. The EOB explains any amounts of charges that may be your responsibility. When your other health plan carrier pays first, send us the original bill with the EOB you have received from them. Usually, that is all we need to process your claim. When Providence Health Plan pays first, attach our EOB to your original bill and send these records to your other insurer. If you have not received an EOB from us, call your Customer Service team and we will send one to you promptly.

*getting pharmacy claims processed* **(Applicable only if your employer has purchased supplemental prescription drug coverage.)** If you are covered by more than one plan for prescription drugs and Providence Health Plan is your secondary plan, then you will have to pay your primary plan's copayment/coinsurance to the pharmacy. We may reimburse you the amount that we owe up to your out-of-pocket costs upon your submission of a Prescription Drug Reimbursement Request form. Submission of this form and your itemized pharmacy receipts is required to obtain reimbursement. This form is available online at [www.providence.org/healthplans](http://www.providence.org/healthplans) or by calling your Customer Service team and requesting one be sent to you.

## Coordination of Benefits

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### **Coordination of benefits**

Sometimes you or your covered dependents are eligible for benefits under another medical insurance plan. If so, benefits for Providence Health Plan covered services will be coordinated with those from the other insurance plan. Providence Health Plan also coordinates benefits with Medicare. This is called coordination of benefits (COB).

Providence Health Plan will coordinate benefits for any “allowable expense.” Allowable expense means any necessary, reasonable and customary item of medical expense, not including dental expenses, at least a portion of which is covered under at least one of the plans covering the person for whom a claim is made. If your employer group plan has a supplemental prescription drug, vision or hearing benefit, allowable expenses will include outpatient prescription drugs, exams and hardware for vision correction or exams and hardware for hearing correction.

**If you have other coverage in addition to your Providence Health Plan coverage, we recommend that you submit your claim to us and to each other insurer at the same time. By doing this, the proper coordinated benefits may be most quickly determined and paid.**

COB is a way to figure out how much each health plan will pay when you have a claim. The total benefits you receive will not exceed the cost of services. One group plan always pays first (primary plan) and the other plan always pays second (secondary plan). Your primary plan will pay for your services under its policy’s terms first, and your secondary plan will pay any member out-of-pocket costs according to its terms. Remember, insurance carriers will pay only for those services which are covered in their plans.

**You must inform Providence Health Plan of your coverage, or your dependent’s coverage, with other insurance plans. Periodically, we will send you a questionnaire asking you to update your other coverage information. Please return this form to us promptly to ensure timely processing of your claims.**

COB between insurance plans is required and governed by federal and state laws. Providence Health Plan will determine coordination of benefits using rules established by these laws to determine the responsibility of each plan.

### *following Providence Health Plan rules*

COB benefits are provided only when you follow Providence Health Plan procedures and requirements as stated in this handbook, regardless of whether Providence Health Plan is considered your primary or secondary plan.

### *determining primary and secondary plans*

The following rules describe the order in which health plans generally provide benefits:

- First – When a plan does not have a provision for coordinating benefits, it is always considered the primary plan.
- Second – The plan in which you are a subscriber.
- Next – The plan in which you are a dependent.

## Coordination of Benefits

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The following rules apply to dependent children:

- If parents are not separated or divorced: The “birthday rule” applies. This rule states that the plan of the parent whose birthday comes first during the year is primary. However, some plans do not follow the birthday rule. In these cases, the rule of the other plan applies.
- If parents are separated or divorced: If a court order makes one parent responsible for paying the child’s health care costs, that parent’s plan is primary. If not, the plan of the parent with custody is primary. If the parent with custody remarries, the secondary plan will then be that of the stepparent. And the plan of the parent who does not have custody will pay third.

If the rules above do not apply, the plan that has covered you longest is the primary plan. However, this rule does not apply if you are covered as an employee who has been laid off or has retired, or as a dependent of that employee. In these cases, the plan covering you as an employee who has been laid off or has retired, or as a dependent of that employee, is the secondary plan. Both plans must follow this rule for it to apply.

If none of the above rules apply, the plan that has covered you longest is the primary plan.

*our right to receive  
and release necessary  
information*

Providence Health Plan may, without your written consent, release to, or obtain from any other insurer, organization or person, any necessary information we need to administer the coordination of your benefits. To claim benefits from Providence Health Plan, you will need to give us the necessary information for this purpose.

*for more information*

Coordination of benefits rules governing payment of claims is complicated and specific. If you need more information about coordinating benefits between two or more health plans, please contact your Customer Service team.

### **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 your Customer Service team if you have questions.

*Medicare “Working Aged”*

Per 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 employees or more, Medicare will be considered the secondary payer.

## Benefits from Other Sources

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### Third-party liability (subrogation)

Sometimes, a third party pays for a member's medical expenses because the member was injured by them.

*Example: You are hurt in a store and the owner was at fault for your injury, the owner or owner's insurance may be responsible for your medical care and services related to your injury.*

In these types of situations, your Providence Health Plan coverage is secondary. We need detailed information from you whenever you use your Providence Health Plan benefits because of:

- a motor vehicle accident;
- workplace accidents;
- injury or illness; or
- any other situation involving injury or illness, including wrongful death, in which you or your heirs, beneficiaries or relatives have a basis to bring a lawsuit or to make a claim for compensation against any person or for which you or your heirs, beneficiaries or relatives may receive a settlement. (Food poisoning or an injury from a defective product are examples of third-party liability.)

Once it has been established that the third party is responsible and capable of paying for the expenses for any services caused by them, Providence Health Plan will not provide benefits for the services arising from the condition caused by that third party.

### recovering money from a third party

Providence Health Plan may recover money from a third party, usually an insurance carrier, who may be responsible for paying for your treatment for an illness or injury. Providence Health Plan may sue in your name, if necessary. If you 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 you 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 you may have commenced.

By accepting membership in Providence Health Plan, you make an agreement with us – if you receive a settlement for an illness or injury, you must pay us back for the cost of your treatment.

*Example: You are injured while on a weekend visit to a coastal resort. You sue, and are awarded \$7,500 plus attorney's fees. Meanwhile, Providence Health Plan has paid a total of \$6,000 for treatment of your injury, so you must reimburse us \$6,000 out of your settlement.*

Before you accept any settlement, you must let us know the terms, and tell the third party that we have an interest in the settlement. If you have medical bills after you receive a settlement, we will not pay those bills until your settlement is exhausted.

If you continue 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 you prove 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 exceeds the amount received in settlement or recovery from the third party.

## Benefits from Other Sources

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We are entitled to reimbursement from any settlement or recovery from any third party even if the total amount does not fully compensate you for other damages, particularly including lost wages or pain and suffering. Any settlement arising out of an injury or illness 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.

If you fail to reimburse us as required, we are entitled to offset future benefits otherwise payable under this plan, or under any future plan with us, to the extent of the value of the benefits advanced under this plan.

***notification*** If you are using your Providence Health Plan benefits for an illness or injury you think may be the responsibility of another party, notify us in writing as soon as possible. In addition, if we identify a claim that may be the responsibility of a third party, we will ask you for more information about how you were injured, and what you are doing to determine the legal liability of the third party who may be at fault.

We also will ask you to agree in writing to the following:

- Repay us for medical expenses that we paid related to your subrogated situation to the extent that the law allows.
- Include our claims paid for you in any claim you make against the party who injured you.
- Prorate any attorney fees that you spent in your recovery related to our repayment.

This agreement requires that you cooperate with us so that we can recover the amount due to us by law.

***motor vehicle coverage*** Oregon law requires motor vehicle liability policies to provide primary medical payment insurance. When coverage is available from motor vehicle liability insurance, Providence Health Plan will be entitled to recover the cost of services provided. Also, we will cover the cost of services in excess of those covered by the motor vehicle insurance per our guidelines. Providence Health Plan's right to recover the amounts it pays is described above.

***our right to receive and release necessary information*** Providence Health Plan may, without your written consent, release to, or obtain from any other insurer, organization or person, any necessary information we need to administer third party liability. To claim benefits from Providence Health Plan, you will need to give us the necessary information for this purpose.

## Termination of Member Coverage

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### When your group coverage ends

#### Providence Health Plan membership and coverage will terminate for subscribers and their dependents if:

- The subscriber gives written notice of cancellation through the employer group.
- The subscriber dies. Coverage for dependents ends on the last day of the month in which the subscriber dies.
- The subscriber is no longer eligible for coverage. The employer group agrees to notify Providence Health Plan immediately of loss of eligibility.
- The employer voluntarily discontinues coverage with Providence Health Plan or the employer fails to pay premiums and Providence Health Plan terminates coverage.

#### Providence Health Plan may terminate membership and coverage upon written notice in the event of (but not limited to) the following:

- The member fails to pay copayments or coinsurance by or for a specific member.
- The member furnishes incomplete, false, or misleading information to Providence Health Plan.
- The member enters full-time military, naval or air service, except as provided under federal USERRA requirements or similar state laws.
- The member permits the use of a Providence Health Plan member identification card by another person or uses another member's identification card to obtain services.
- The member misuses his or her Providence Health Plan benefits, including use of emergency services, causes damage to a provider's or hospital's property, or is physically or verbally abusive toward the providers who are providing services, a provider's employee, or an employee of Providence Health Plan.
- If the member's employer group, or if the member (under a COBRA continuation or Portability coverage plan) fails to pay any premium due to Providence Health Plan within 31 days of the due date.

### Certificate of Creditable Coverage

When you leave Providence Health Plan, you and/or your dependents will receive a form called a Certificate of Creditable Coverage which provides proof of prior medical coverage. You may need to furnish this certificate to another insurance carrier to obtain medical coverage in the future.

#### We will provide you with a Certificate of Creditable Coverage when:

- You cease to be covered by Providence Health Plan.
- You cease to be covered under COBRA coverage.
- You request a Certificate of Creditable Coverage within 24 months of your termination of coverage.

## Continuation and Portability Coverage

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### **COBRA continuation employer groups with 20 or more employees**

COBRA, an acronym for “Consolidated Omnibus Budget Reconciliation Act,” is a federal law. It requires employers with 20 or more employees to offer employees and/or their dependents temporary continuing medical coverage when they experience a qualifying event. Administrative procedures for COBRA continuation enrollment and premium payment are handled by the employer. Payment of claims for members enrolled in COBRA continuation coverage is handled by Providence Health Plan.

#### **For the subscriber, qualifying events include:**

- reduced work hours; and
- termination of employment for any reason other than gross misconduct.

#### **For dependents, qualifying events include:**

- the subscriber’s reduced work hours
- the subscriber’s termination of employment for any reason other than gross misconduct
- the subscriber’s death
- the subscriber’s enrollment in Medicare
- divorce or legal separation from the subscriber
- loss of eligibility as a dependent child

It is your employer’s responsibility to offer you and/or your dependents COBRA continuation coverage when you, the subscriber, terminate employment, reduce work hours, die, become covered by Medicare or lose retiree benefits because your employer files bankruptcy under title 11 of the United States Code.

The subscriber and/or the subscriber’s covered dependents are responsible for notifying the subscriber’s employer when a dependent’s eligibility status changes; for instance, when a dependent no longer qualifies as an eligible dependent due to legal separation or divorce or a dependent child loses eligibility for coverage as a dependent child. The employer must be notified within 60 days after the event. The employer is then responsible for offering you and/or your dependents COBRA continuation coverage.

### ***when COBRA continuation coverage begins***

You or your family member must elect COBRA continuation coverage within 60 days after your benefit plan group coverage ends due to a qualifying event or, if later, 60 days after you received your COBRA continuation election notice. If you elect COBRA continuation coverage, your COBRA continuation coverage will begin the day after your benefit plan group coverage terminated as a result of your qualifying event.

If you do not elect COBRA continuation coverage within the previously stated 60-day timeframe, your benefit plan group coverage will end on the date you ceased to be eligible for Providence Health Plan group coverage due to the qualifying event.

## Continuation and Portability Coverage

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*length of  
continuation coverage*

COBRA continuation coverage lasts for up to 18 months for the subscriber and/or dependents, when the qualifying event is:

- the end of the subscriber's employment; or
- a reduction of the subscriber's work hours

COBRA continuation coverage lasts for up to 36 months for the dependents, when the qualifying event is:

- the death of the subscriber;
- the subscriber's enrollment in Medicare;
- legal separation or divorce from the subscriber; or
- a dependent child losing eligibility as a dependent child

If the subscriber or a covered dependent is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage, the COBRA continuation coverage period may be extended 11 additional months for a total maximum of 29 months. To be entitled to the extended coverage period, the disabled subscriber/dependent must provide notice to the subscriber's employer within the initial 18-month COBRA continuation period and within 60 days after the date of the determination of disability under the Social Security Act. If an individual is entitled to the extended COBRA continuation coverage period, any non-disabled family members who are entitled to COBRA continuation coverage also are entitled to the additional 11 months of coverage.

In addition, if your family experiences a second qualifying event while receiving COBRA continuation coverage, the covered spouse and dependent children in your family can receive additional months of COBRA continuation coverage, up to a total maximum of 36 months. In all cases you must provide notice to the subscriber's employer within 60 days of the second qualifying event.

If you have any questions about your COBRA continuation coverage, please contact the subscriber's employer.

In order to protect your family's COBRA continuation rights, you should inform the subscriber's employer of any changes in addresses of covered family members. You should also keep a copy of any notices you send to the subscriber's employer for your records.

**COBRA continuation coverage will be terminated by Providence Health Plan on the earliest date that you no longer qualify for such coverage in accordance with federal COBRA regulations.**

## Continuation and Portability Coverage

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*special notice* If you are a surviving, divorced or legally separated spouse of the subscriber and are at least 55 years old at the time of death or the dissolution or legal separation of the marriage, the 36-month maximum extension of COBRA continuation coverage may not apply. Instead, you may be eligible to continue coverage under an Oregon state mandate until the earliest of the following dates:

- The date you fail to pay premiums when due, including any grace period. (Coverage will be retroactively terminated on the last day of the month through which the premium was paid.)
- The date that the Employer Group Contract terminates.
- The date on which you become insured under another group health plan that does not exclude or limit your treatment for pre-existing conditions, whether by remarriage or not.
- The date on which you become eligible for federal Medicare coverage.

Your covered dependent children also remain eligible for COBRA continuation coverage until the earliest of the above dates as long as you remain enrolled and they remain otherwise eligible under the terms of your benefit plan.

### **State continuation employer groups with 19 or less employees**

State of Oregon mandated continuation of coverage is available to you or your family member if you have been covered continuously by Providence Health Plan, or a similar predecessor group health plan, during the three month period on the date of termination of employment or membership.

**IMPORTANT NOTE:** You must request state continuation coverage in writing and pay your premium in advance to your ex-employer within 31 days after the date on which your employer group coverage would otherwise end.

#### **You may be eligible for continuation of coverage if:**

- Your coverage ends because of the termination of employment of the subscriber.
- Your coverage ends because the subscriber's reduction in work hours.
- Your coverage ends because of the death of your spouse, the dissolution of your marriage or a legal separation.
- In the case of dependent children, when your children no longer meet eligible family dependent requirements.

#### **State continuation of group coverage terminates the earlier of:**

- Six months after the date on which the subscriber's coverage under his or her employer group plan otherwise would have ended because of termination of employment or membership.
- Six months after the start of a leave of absence from which a subscriber does not return to work.
- Nonpayment: The end of the month for which you last made timely payment (30 days from the date the premium is due).
- Medicare: The first of the month in which you become entitled to Medicare benefits.
- Other Group Coverage: The date you become covered under another group health plan as a covered employee or as a dependent.
- Remarriage: The date the former spouse remarries and, because of the remarriage, becomes covered under another group health plan.

## Continuation and Portability Coverage

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### **Portability coverage**

If you lose eligibility for group coverage or COBRA continuation coverage by Providence Health Plan, you may be eligible for Portability coverage. You must apply for Portability coverage within 63 days of your loss of eligibility. You also can apply for Portability coverage any time during your COBRA continuation coverage. Call your benefits office or your Customer Service team to find out how to make such a change.

You will have a choice of two Portability Plans, the Prevailing Cost Benefit Plan or the Low Cost Benefit Plan. Portability Plans are new contracts and not a continuation of your terminated group coverage. Portability Plan benefits and premiums are different from those provided under your group coverage. The benefits that may be available to you are described in an outline of coverage provided to you when you request an application for a Portability Plan from us. Portability Plans may be issued covering each former member on a separate basis or issued covering all former members together. Contact your Customer Service team to get additional information.

**IMPORTANT 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.

**To be eligible for Portability Coverage, you must reside in Oregon and meet the following requirements:**

1. You must have been covered under one or more Oregon group health insurance plans for at least 180 days **or** you must have 18 or more months of Creditable Coverage; and
2. You must apply for Portability coverage within 63 days of the termination of your Providence Health Plan group coverage.

**Only persons covered under your employer's group plan on the date coverage terminates are eligible to be covered under a Portability Plan.**

**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 or individual plan, policy, contract, or agreement providing benefits for hospital or medical care; **or**
4. You move out of Oregon.

# Member Rights and Responsibilities

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**Introduction** As a member of our 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're ready to help in any way.

**Your rights** 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 physician or provider 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.

**Your responsibilities** You have the responsibility to:

- Read and understand the information you receive about Providence Health Plan, and call Customer Service if you have questions.
- 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 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 identification 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.

## Member Rights and Responsibilities

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- 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.

### **Our responsibilities**

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.

## Problem Resolution

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### **Informal member problem resolution**

All Providence Health Plan employees share responsibility for ensuring member satisfaction. If you have a problem or concern about your coverage, or services you have received, let us know what the problem or concern is and how you would like it to be addressed.

Your Customer Service team is available to provide information and assistance. You may call us or set up an appointment with us to discuss your concern. If you have special needs, such as a hearing impairment, call our TTY (telephone device for the hearing impaired) number. Please contact us so we may help you with whatever special needs you may have.

### **Assistance outside Providence Health Plan**

At any time during the grievance and appeal process you may seek assistance from the Oregon Insurance Division with your concerns regarding our decisions and benefits. You may contact the Oregon Insurance Division at:

Oregon Insurance Division  
Consumer Protection Unit  
350 Winter St. NE, Room 440  
Salem, OR 97301-3883  
1-503-947-7984 or 1-888-877-4894  
E-mail: [dcbs.inmail@state.or.us](mailto:dcbs.inmail@state.or.us)  
Internet: <http://insurance.oregon.gov/>

If your group coverage is under a plan that is subject to the federal Employee Retirement Income Security Act of 1974 (ERISA) requirements for employee benefit plans (typically all employer sponsored plans except those of a state or local government or a church organization are subject to ERISA) then you have a right to bring a civil action under ERISA regarding a denial of benefits after you have completed the first level of appeal.

### **Your grievance and appeal rights**

If you disagree with Providence Health Plan's decision about your medical bills or health care services you have the right to appeal. You may appeal if you believe that we have not paid a bill, have paid a bill incorrectly, will not approve care that you think should be covered or are stopping care you believe you still need. You also may 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. To the extent possible, complaints filed by telephone will be resolved at the point of service by your Customer Service team. All levels of Grievances and Appeals will be acknowledged within seven days of receipt by Providence Health Plan and resolved within 30 calendar days, or sooner depending on the clinical urgency. With regard to the initial grievance, an additional 15 days may be requested to resolve the issue if, before the 30<sup>th</sup> day, we provide you with notice of the delay, including the reason for the delay.

#### **In filing a grievance or appeal:**

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

## Problem Resolution

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### **Appeals involving prior authorization denials**

If you appeal a prior authorization request that has been denied by Providence Health Plan for a non-urgent medical condition, we will notify you of our initial grievance decision or first level appeal decision within 15 days after we receive your appeal. For second level appeals, we will notify you within 30 days.

If you believe your health would be seriously harmed by waiting for our decision on your prior authorization request, grievance or appeal, you may request an expedited review by calling your Customer Service team. 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 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 reconsiderations 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.

### **Initial grievance**

If you disagree with our decision you have the right to file an initial grievance. You must file your initial grievance within 180 days of the date on our notice of initial decision or that initial decision will become final. Please advise us of any additional information that you want considered in the review process.

If you are seeing a provider that does not participate with Providence Health Plan, you should contact the provider's office and sign a release of records form for the necessary records to be forwarded to Providence Health Plan for the review process.

### **First level of appeal**

If you disagree with our decision on your initial grievance, you have the right to file a first level of appeal. Your appeal and any additional information you may want reviewed should be forwarded within 60 days from the date on the initial grievance denial notice, or that denial will become final. The first level of appeal will be reviewed by Providence Health Plan staff not involved in the initial grievance. If your appeal involves a denial of services because they are not medically necessary or because they are experimental/investigational, your appeal will be handled as a second level appeal.

### **Second level of appeal**

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

## Problem Resolution

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### External review

If you are not satisfied with the decision from 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, or because they are experimental/investigational, you may request an external review by an Independent Review Organization (IRO). **Your request must be made within 180 days after you receive Providence Health Plan's final internal review decision from the Grievance Committee 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 director's office 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 director's office.

**Providence Health Plan agrees to be bound by the decisions of an IRO regarding medically necessary treatment, notwithstanding the definition of medical necessity, experimental/investigational treatment and an active course of treatment for purposes of continuity of care, and to comply with those decisions.** All costs for the handling of external review cases are paid by Providence Health Plan and these provisions are administered in accordance with the regulatory requirements established by law and regulation in the state of Oregon.

### How to submit grievances or appeals

Contact your Customer Service team 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  
Attn: Appeals and Grievance Dept.  
P.O. Box 4327  
Portland, OR 97208-4327**

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

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

### Additional information

If you would like to receive our annual report on grievances and appeals, please contact your Customer Service team.

## New Technology Policy

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### *new application of existing technology coverage determination*

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 which 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 which do 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 is made on a case-by-case basis. This is separate and distinct from the problem resolution procedure set forth on pages 74-76.

## Miscellaneous Information

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### **Additional information available upon request**

The following information about Providence Health Plan is available from the Oregon Insurance Division:

- Financial information
- Annual summary of grievances and appeals
- Annual summary of utilization review policies
- Annual summary of quality assessment activities
- Annual summary of network monitoring to ensure that all covered services are reasonably accessible to members
- A summary of the results of all federal reports and accreditation surveys available to the public
- A summary of health promotion and disease prevention activities

This information is available by calling 1-503-947-7984 or by writing to:

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

You also can contact them electronically at:

E-mail: [dcbs.insmail@state.or.us](mailto:dcbs.insmail@state.or.us)

Internet: <http://insurance.oregon.gov/>

### **Notice of provider termination**

When a participating physician, Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), or a participating mental health provider terminates from Providence Health Plan, we will notify those members who we know are under the care of the terminated physician/provider within 10 days of either the termination date, or of our knowledge of the termination date.

### **Change in or termination of benefits**

Employer groups renew their plan contracts with Providence Health Plan on an annual basis. At the time of renewal, if there are benefit changes for your employer group plan, we will send you a new Summary of Benefits and Member Handbook documents that describe your benefits for your employer's new plan contract year. If, for any reason, there is a change in your benefits in the middle of any plan contract year, you will receive a benefit change letter from Providence Health Plan describing the applicable changes.

In certain cases, a member may no longer be eligible for coverage from Providence Health Plan or Providence Health Plan may make a decision to terminate membership. These situations would result in a termination of benefits. *Please refer to "termination of member coverage," page 67, for more detailed information.*

### **Privacy of member information**

Medical care is a deeply personal issue for people. All of us need to know that information about our health care is private and confidential. 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.

## Miscellaneous Information

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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:

- We will use the information to administer your plan benefits and help pay your medical bills that have been submitted to us by doctors and hospitals for payment.
- We may share your information with your doctors or hospitals to help them provide medical care to you. For example, 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. For example, 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.
- To give you information about alternative medical treatments and programs or about health related products and services that you may be interested in. For example, we sometimes send out newsletters that let you know about “healthy living” alternatives such as smoking cessation or weight loss programs.

Providence Health Plan makes every effort to release only the amount of information necessary to meet any release requirement and only releases information on a need to know basis. Also, wherever feasible, identifiable information is removed from any information shared within and outside of Providence Health Plan. To secure the confidentiality of medical information, we have the following procedures in place:

- Access to a member’s medical information held by the plan is restricted to only those Providence employees who need this information and to the member. Entries into member records are tracked for security purposes. Employees must report any security violations.
- Unique and secured log-in names and passwords are required to access the Providence Health Plan computer system. In addition, “firewalls,” encryption and data backup systems are used. Similar strategies are used for protecting confidential information on our Internet site.
- Providence employees are educated about privacy issues and sign a confidentiality statement upon employment, then review the information and sign again each year.
- Each department within Providence Health Plan adopts specific policies to monitor the handling of member information.
- Members must sign an authorization to release identifiable member information outside of Providence Health Plan or its authorized agents, except when the law requires or permits such a release or for treatment, billing and health care operations.
- 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 Providence Health Plan members is completely protected.

## Miscellaneous Information

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- Our agreements with participating providers contain confidentiality provisions that require providers treat your personal health information with the same care as Providence Health Plan.
- 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 on our Web site at [www.providence.org/healthplans](http://www.providence.org/healthplans) or by calling your Customer Service team.

### **Member forums**

Your input is valuable to us. Periodically, forums may be held where members, providers and employers/purchasers present their views and suggestions to the executive staff of Providence Health Plan. This input assists us in developing meaningful policies that benefit all members. Future meeting times and locations may be announced in the Providence Health Plan member newsletter.

### **Non-discrimination**

Providence Health Plan will not refuse to enter into, cancel or decline to renew a contract because of any member's race, color, national origin, religion, status as a victim of domestic violence, gender, sexual orientation, marital status or age.

### **Prescription drug formulary information**

For prescription drug formulary and cost-sharing information, please refer to your plan's Prescription Drug Summary of Benefits enclosed in your member packet. **(This section is applicable only for members with a supplemental prescription drug benefit.)**

### **Quality management**

If you would like to receive a summary of Providence Health Plan's programs to monitor and improve the quality of health services in the community, please contact your Customer Service team.

### **Provider payments**

Providence Health Plan pays participating providers on a discounted fee-for-service arrangement. Hospitals are reimbursed based on the services they provide. The hospitals are motivated to provide the right amount of care in the proper setting for their patients. Hospitals work with personal physicians/providers and other providers to give members quality care and to keep health care costs within budget.

### **Payment of premiums**

Premium payments by the employer or member are generally due on the first day of the month, or as stated in your Employer Group Contract. Late premium payment may result in the suspension of claims payment. Termination of coverage will occur on the last day of the month through which premiums are paid.

### **Additional information**

If you would like to receive additional detailed information regarding the reimbursement arrangements Providence Health Plan holds with our participating providers, please call your Customer Service team.

## Miscellaneous Information

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### Utilization management

Providence Health Plan works with physicians and other health care providers to offer appropriate medical care and to improve the health of our members. Your health is our first priority.

We support providers to make sound medical decisions on behalf of their patients, our members. That support may include furnishing information to your provider to help manage your health care. For example, we may review your recent treatment history to determine your personal physician/provider and then:

- Suggest a disease management or wellness program that could improve your health.
- Provide a profile of prescription drug usage to help coordinate your overall care.

We do not offer incentives or reward any provider or Providence Health Plan staff for denying claims or not providing care. We encourage providers to explain all medical options to members, whether those options are covered by Providence Health Plan or not. We want you and your provider to work together to make the best decisions for treatment.

We encourage providers to manage and improve care for our members, not to restrict care. Like most health plans, we do have some restrictions about which benefits are covered by the plan purchased by your employer, by you as an individual or by a government contract. We explain what benefits are covered in your Member Handbook so you can know about those in advance.

We do ask you whenever possible to work with participating health care providers who have agreed in advance to our schedule of fees, to our routines of care known as clinical practice guidelines, and who will refer you to other care providers with whom we work. The health care providers we ask you to work with are listed in our Online Participating Provider Directory for Open Option plan members and in a paper directory that you can receive from us by calling your Customer Service team.

Providence Health Plan does require advance notification – or prior authorization – from providers for some medical procedures. This allows the plan to commit to appropriate payment for these services and ensure their medical appropriateness. This may include review of the member’s medical records by appropriate Providence Health Plan clinical staff so that we ensure appropriate application of benefits and payments. Also, we provide case management assistance for members with complex medical needs who may benefit from additional assistance to maximize and coordinate the care they receive from health care providers.

If you have a prescription drug benefit through your employer’s plan, you should know that Providence Health Plan recommends the use of generic formulas. Some drugs will require prior authorization for benefit payment, or may be paid only equal to the generic drug equivalent. We frequently update the types of prescription drugs we cover. If you would like to know which drugs require prior authorization or to what benefit level a specific medication is covered, please contact your Customer Service team.

If you want more information about how Providence Health Plan makes decisions about covering medical treatment (also called “utilization management”), please call your Customer Service team.

# ERISA Information

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## Your ERISA rights

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 the ERISA, which provides that all Providence Health Plan participants are entitled to:**

### **1. 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 their 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 their 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.

### **2. Continue group health plan coverage**

- Continue health care coverage for yourself, spouse or dependents 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 "COBRA continuation," pages 68-71, for more information.*)
- Receive a reduction or elimination of exclusionary periods of coverage for preexisting 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 "Certificate of Creditable Coverage," page 67, for more information.*)

### **3. 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.

## ERISA Information

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### **4. 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).

### **5. 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.

### **Amendment or termination of plan**

The employer sponsor of your group plan reserves the right at any time to amend or terminate in whole or part any of the provisions of the plan or any of the benefits provided under the plan. Any such amendment or termination 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.

## Definitions

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**Acute care** is care received in an inpatient hospital setting.

A **calendar year** marks the time beginning January 1 and ending December 31.

A **Certificate of Creditable Coverage** provides proof of prior medical coverage. You may need to furnish this certificate to another insurance carrier to obtain medical coverage in the future.

A **certified nurse midwife** is a person who is licensed or certified to supervise the conduct of labor and childbirth; advise the parent as to the progress of the childbirth; and furnish prenatal, intrapartum, and postpartum care.

**Chemical dependency** is 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 is not an addiction to, or dependency on tobacco, tobacco products or foods.

**Coinsurance** is the percentage of cost that you may need to pay for a covered service. Coinsurance amounts are listed on your Summary of Benefits.

A **condition** is an impaired state of health, due to a specific illness or injury that requires skilled professional treatment or services.

A **copayment** is the fixed dollar amount you pay for a covered service at the time the care is provided. Copayment amounts are listed on your Summary of Benefits.

**Cosmetic treatment** is defined as medical or surgical treatment primarily for the purpose of improving appearance or self esteem.

**Custodial care services** are services or supplies that do not require the technical skills of a licensed nurse at all times, assist solely in activities of daily living activities or personal grooming and are not likely to improve your condition.

**Dependent** means a person who is supported by you or your legal spouse. *See "eligible dependents," page 6-7, to determine dependent eligibility requirements.*

**Developmental delay** is defined as a delay in the ability to learn, reason or communicate.

**Domestic Partner** means a person who is at least eighteen (18) years of age, 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 this group health plan that apply to a spouse shall apply to a Domestic Partner.

**Durable medical equipment (DME)** is equipment which is primarily and customarily used to serve a medical purpose, and generally is not useful to a person in the absence of illness or injury. It can withstand repeated use and is generally considered to be safe and effective for the purpose intended. DME may include items such as oxygen, wheelchairs, and other medically necessary equipment required for the treatment of an illness or injury.

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.

An **employer group** refers to the organization whose employees are covered by Providence Health Plan.

# Definitions

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**Experimental/investigational**, means any services determined by Providence Health Plan or our authorizing agent to not be medically necessary or accepted medical practice in the service area. In determining whether services are experimental or investigational, Providence Health Plan will consider whether services are, in general: used in the medical community in the state of Oregon; under continued scientific testing and research; show a demonstrable benefit for a particular illness or disease; proven to be safe and efficacious; and approved for use by appropriate government agencies. Providence Health Plan includes a determination 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 or safety of the patient. Providence Health Plan retains documentation of the criteria used to define a service deemed to be experimental or investigational and will make this available for review upon request.

A **family practice physician** is a licensed personal physician/provider trained to diagnose and provide health care to patients of all ages. These providers are trained to provide routine gynecological care (including the annual gynecological exam) and some also provide obstetric care.

A **general practice physician** is a licensed personal physician/provider trained to diagnose and provide health care services, including routine gynecological care and the annual gynecological exam, to patients of all ages.

A **gynecologist** is a licensed physician specializing in the diagnosis and treatment of the diseases of women's reproductive systems. Some gynecologists have been approved to act as personal physicians/providers and will be listed as such in the Online Participating Provider Directory.

A member **identification card** is issued to each member enrolled in Providence Health Plan. The card identifies you as a Providence Health Plan member and includes important information about your coverage. Always present your card when you seek medical care or benefits.

An **internist** is a licensed personal physician/provider who is trained to diagnose and provide health care services to adults and teens, including routine gynecological care and the annual gynecological exam for women.

The **lifetime maximum benefit** is the total dollar amount of benefits payable by us during the lifetime of a member and is shown on your Summary of Benefits. For each calendar year that a member is enrolled on this plan, we will restore to the member's lifetime maximum benefit on January 1st, the following amount:

- If the benefits we pay for covered services in the calendar year total \$25,000 or less, we will restore the full amount of the benefits paid to the member's lifetime maximum benefit.
- If the benefits we pay for covered services in the calendar year are in excess of \$25,000, then we will restore \$25,000 to the member's lifetime maximum benefit.

**Medically necessary** refers to treatment which, as determined by Providence Health Plan, is required to treat or care for symptoms of an illness or injury or to diagnose an illness or condition that is harmful to life or health. Medically necessary services or supplies must be: appropriate as to place or level of care in amount, duration, and frequency for the treatment of the condition; not be provided primarily for convenience; appropriate and in keeping with widely-accepted standards of practice in the community; and likely to stabilize or improve a member's medical condition. The fact that services are provided, prescribed or approved by a physician or provider does not in and of itself mean that the services are medically necessary.

**Members** are the eligible individuals covered by Providence Health Plan.

## Definitions

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**Mental health** is defined as services related to all disorders listed in the “Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition” except for:

- 1) Diagnostic codes 317, 318.0, 318.1, 318.2 and 319 relating to Mental Retardation;
- 2) Diagnostic codes 315.00, 315.1, 315.2 and 315.9 relating to Learning Disorders;
- 3) Diagnostic codes 302.2, 302.4, 302.81, 302.82, 302.83, 302.84, 302.89 and 302.9 relating to Paraphilias;
- 4) 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
- 5) Diagnostic codes V15.81 through V71.09, “V” codes. This exception does not extend to children five (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).

A **nurse practitioner** is a licensed nurse who has a Master’s Degree in nursing and advanced training which allows him or her to provide primary care. Some nurse practitioners have been approved to act as personal physicians/providers and will be listed in our Online Participating Provider Directory.

**Out-of-pocket maximum** is the limit on the amount of money you will have to spend for specified covered health services in a calendar year. This maximum amount is shown on your Summary of Benefits. Some expenses do not apply to your out-of-pocket maximum, as listed on pages 19-21.

An **obstetrician** is a provider specializing in the medical care related to pregnancy and the birth of children. Some obstetricians have been approved to act as personal physicians/providers and will be listed in our Online Participating Provider Directory.

A **pediatrician** is a personal physician/provider trained to diagnose and provide health care services to infants, children, and adolescents.

A **physician assistant** provides medical services under the direction and supervision of a licensed physician. Some physician assistants have been approved to act as personal physicians/providers and will be listed in our Online Participating Provider Directory.

A **participating provider** or Providence Health Plan provider is any credentialed physician, provider, hospital, or facility which has an agreement with Providence Health Plan to provide care to our members.

**Prior authorized services** are services which require you and/or your provider to seek Providence Health Plan confirmation before seeking or receiving care. A prior authorization review will determine if the proposed service is medically necessary, eligible as a covered service and if an individual is a member at the time of the proposed service.

A **personal physician or provider** is a provider specializing in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; a certified nurse midwife; 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 select 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 physician/provider. (Note: Not all these providers are personal physicians/providers — see the Online Participating Provider Directory for a listing of designated personal physicians/providers.)

A **qualified practitioner** means a physician, women’s health care provider, nurse practitioner, certified nurse practitioner midwife, clinical social worker, physician assistant, psychologist, dentist, or other practitioner who is professionally licensed by the appropriate state agency to diagnose or treat an injury or illness and who provides covered services within the scope of that license.

The Providence Health Plan **service area** is a defined geographical area where members either must work or reside. See our service area map on page 89.

## Definitions

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A **skilled nursing facility (SNF)** is a convalescent or chronic disease facility which is accredited by the Joint Commission on Accreditation of Hospitals or certified as an “SNF” by the Secretary of Health & Human Services according to Title XVIII of the Social Security Act.

A **specialist** is a nurse, physician or other health care professional who has advanced education and training in one clinical area of practice.

A **subscriber** is the employee of the Group whose employment or membership in the Group establishes eligibility for his or her dependents under the Providence Health Plan policy.

The **Summary of Benefits** is a description of your Open Option health care coverage and shows your copayments and coinsurances for covered services. Your plan’s coverage may include additional supplemental benefits. If this applies to you, each supplemental benefit is explained in a separate Summary of Benefits included in your member materials.

**Supplemental benefits** are any benefits purchased by your employer in addition to your Open Option health care coverage. Examples are: prescription drug, alternative care, chiropractic care, vision care and elective sterilization. If your plan includes coverage for supplemental benefits, your member materials will include a Summary of Benefits for each supplemental benefit. Not all members have these supplemental benefits. Check your Summary of Benefits and member materials to determine if your coverage includes supplemental benefits.

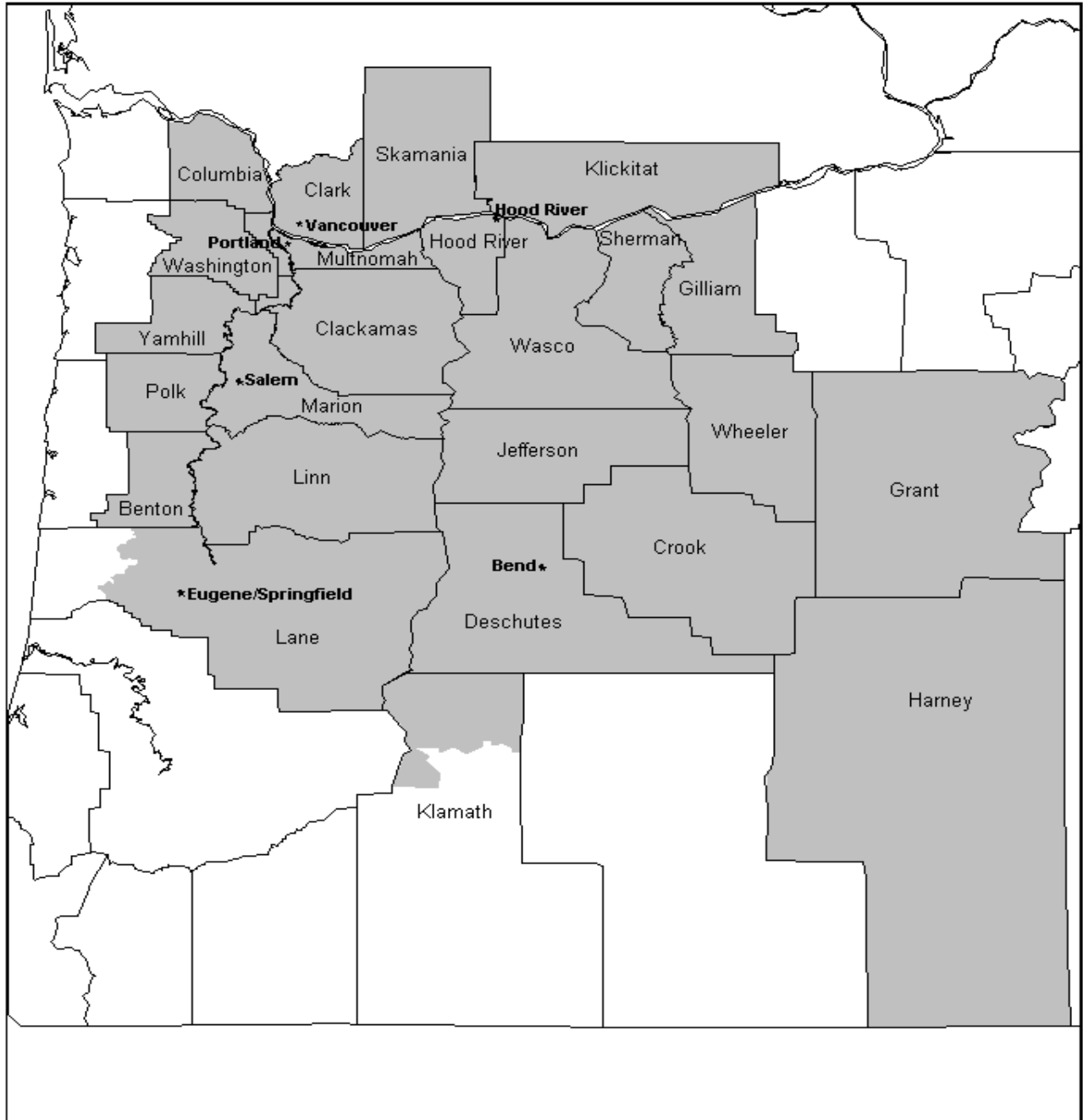
**Usual, customary, and reasonable charges (UCR)** are charges that Providence Health Plan determines fall within a range of those most frequently charged for services and supplies. The amount determined is based on charges in the community where the services and supplies were furnished, by those who provide them. UCR charges do not include sales taxes, handling fees and similar surcharges and such taxes, fees and surcharges are not covered expenses.

A **women’s health care provider** is an obstetrician, gynecologist, physician assistant specializing in women’s health, advanced registered nurse practitioner specializing in women’s health, or a certified nurse midwife practicing within the applicable lawful scope of practice. Naturopaths or any other alternative care providers are **not** considered women’s health care providers.

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# Service Area Map



■ = Current service area

## Service area zip codes:

**State of Washington** - all zip codes in Clark, Klickitat and Skamania counties.

**State of Oregon** - all zip codes in Benton, Clackamas, Columbia, Crook, Deschutes, Gilliam, Grant, Harney, Hood River, Jefferson, Linn, Marion, Multnomah, Polk, Sherman, Wasco, Washington, Wheeler and Yamhill counties.

**Selected zip codes in Lane County** - 97488, 97490, 97487, 97492, 97401, 97478, 97455, 97489, 97427, 97454, 97452, 97451, 97488, 97440, 97438, 97437, 97482, 97431, 97477, 97426, 97424, 97420, 97472, 97434, 97461, 97419, 97403, 97404, 97405, 97408, 97409, 97412, 97413, 97463.

**Selected zip codes in Klamath County** - 97425, 97733, 97737.