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1. INTRODUCTION

Thank you for choosing Providence Health Plan. We look forward to meeting your health care needs. The following is a brief outline of key provisions of your Providence Connect Individual & Family Plan Contract.

- Some capitalized terms have special meanings in this contract. Please see section 12, Definitions.
- In this document, Providence Health Plan is referred to as “we,” “us” or “our.” Members enrolled under this Contract are referred to as “you” or “your.”
- If after examining this Contract you are not satisfied with it for any reason, you may cancel this policy within 10 days of receipt. Your decision to cancel this policy must be provided to us in writing within the 10 day period, and we will provide a full refund of your premium and consider the policy void and never effective.
- Coverage under this Individual & Family Plan is provided through our Providence Connect Network of Medical Homes and Network Providers.
- Covered Services must be obtained from Network Providers, with the following exceptions:
  - Emergency Services and Urgent Care Services, as specified in sections 4.5; and
  - Covered Services delivered by an Out-of-Network Provider when those Services have been approved in advance through the Prior Authorization procedures specified in section 3.7.
- All Members are encouraged to choose a Medical Home Primary Care Provider who will provide preventive and primary care Services and coordinate other care in a convenient and cost-effective manner.
- A printable directory of Network Providers in our Service area is available at: [http://phppd.providence.org/](http://phppd.providence.org/). Members without Internet access who would like a hard copy of the provider directory may contact Customer Service for assistance.
- In order to receive coverage for Services received from network Providers outside of the Medical Home, you must obtain a Medical Home Referral from your Medical Home before you receive the Services.
- Certain Covered Services require an approved Prior Authorization, as stated in section 3.6.
- Coverage under this Individual & Family Plan is available 24 hours a day, seven days a week and during periods of domestic or foreign travel.
- Enrolled Policyholders, enrolled Spouses, and Dependent-only Members must reside in our Oregon Service Area, as shown in section 13.
- The Contract for this Individual & Family Plan Plan includes this document, the Benefit Summary, any endorsements or amendments that accompany those documents, and those policies maintained by Providence Health Plan which clarify any of these documents. In the event of any conflict between these documents, they are to be interpreted in the following order of priority: (1) endorsements and amendments, (2) Contract, (3) Benefit Summary, and (4) applicable Providence Health Plan policies.
2. WELCOME TO PROVIDENCE HEALTH PLAN

Providence Health Plan is an Oregon licensed Health Care Services Contractor whose parent company is Providence Health & Services. This Plan provides access to a network of hospitals, clinics, urgent care centers, physicians, and other health care providers. Our goal is to help improve the health status of individuals in the communities in which we serve.

2.1 YOUR CONNECT PLAN

Your Connect Plan allows you to receive Covered Services from your Medical. Your Plan benefit also provides coverage for Services to other Network Providers when you access these providers through a Medical Home Referral.

IMPORTANT NOTE: If a provider is a Network Provider with Providence Health Plan but is not part of your Medical Home, coverage will not be provided under your In-Network benefits unless you have a Medical Home Referral to that provider.

Your Medical Home will work with us to Prior Authorize treatment.

It is your responsibility to verify whether or not a physician/provider, Hospital or other facility is part of your Medical Home, is a Network Provider, and whether or not the health care is a Covered Service even if you have been directed or referred for care by your Medical Home or a Network Provider.

If you are unsure about a physician/provider’s, Hospital’s or other facility’s participation with Providence Health Plan, visit our Provider Directory, available online at ProvidenceHealthPlan.com, before you make an appointment. You also can call Customer Service to get information about a provider’s participation with Providence Health Plan and your benefits. If you are searching for a Medical Home, be sure to confirm that the provider you have selected is a Medical Home for your Plan and is accepting new patients.

Whenever you visit a Provider:

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

2.2 YOUR INDIVIDUAL & FAMILY PLAN CONTRACT

Your Individual & Family Plan Contract contains important information about the health plan coverage we offer to our Members. It is important to read this Contract carefully as it explains your Providence Health Plan benefits and Member responsibilities. If you do not understand a term that is used, you may find it in Definitions, section 12. If you need additional help understanding anything in this document, please call Customer Service at 503-574-7500 or 800-878-4445. See section 2.3 for additional information on how to reach Customer Service.

This Individual & Family Plan Contract is not complete without your:

• Providence Connect Benefit Summary and any endorsements or amendments to those documents. These documents are available at ProvidenceHealthPlan.com when you register for a myProvidence account as explained in section 2.4. Benefit Summaries detail your
Copayments and Coinsurance for Covered Services and also provide important information about your Benefits.

- **Provider Directory** which lists Connect Providers, available online at ProvidenceHealthPlan.com. If you do not have Internet access, please call Customer Service to obtain a hard copy of the directory.

If you need more detailed information for a specific problem or situation, contact Customer Service.

### 2.3 CUSTOMER SERVICE

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

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

**Contacting Providence Customer Service**

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

- **Members in the Portland-metro area**, please call 503-574-7500.
- **Members in all other areas**, please call toll-free 800-878-4445.
- **Members with hearing impairment**, please call the TTY line 711.

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

### 2.4 REGISTERING FOR A MYPROVIDENCE ACCOUNT

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

### 2.5 YOUR MEMBER ID CARD

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

- Your Member number
- Important phone numbers

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

When scheduling an appointment or receiving health services, identify yourself as a Providence Health Plan Member, present your Member ID Card and pay your Copayment or Coinsurance.

**Please keep your Member ID Card with you and use it when you:**

- Visit your health care provider or facility.
- Register online for your myProvidence account.
- Call for Mental Health/Alcoholism Treatment Customer Service.
- Call or correspond with Customer Service.
• Call Providence RN medical advice line.
• Visit your pharmacy for prescriptions.
• Receive Immediate, Urgent or Emergency Care Services.

2.6 PROVIDENCE NURSE ADVICE LINE
503-574-6520; toll-free 800-700-0481; TTY 711
The Providence nurse advice line is a free medical advice line for Providence Health Plan Members. Available 24 hours a day, seven days a week, a registered nurse can answer your health-related questions.

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

Please have your Member ID Card available when you call.

2.7 PRIVACY OF MEMBER INFORMATION
At Providence Health Plan, we respect the privacy and confidentiality of your protected health information (PHI). Providence Health Plan takes great care to determine when it is appropriate to share your PHI, in accordance with federal and state privacy laws. We use protected health information and may share it with others as part of your treatment, payment for your treatment, and our business operations.

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

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

To secure the confidentiality of medical information, we have procedures in place which you can review at ProvidenceHealthPlan.com/privacy.

When Member information is used in health studies, identifiable information is not released. All Member-specific information has identifying information removed, and aggregated data are used as early in the measurement process as possible. The privacy of our Members is completely protected.
Our agreements with Network Providers contain confidentiality provisions that require providers to treat your personal health information with the same care.

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

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

For more information about uses and disclosures of Member information, including uses and disclosures required by law, please refer to our Notice of Privacy Practices. A copy is available at ProvidenceHealthPlan.com/privacy or by calling Customer Service.

**Appointment of Authorized Representative**

You are entitled to appoint an individual to act as your authorized representative to pursue any claim you have for benefits. To ensure privacy and to address other issues, Providence’s policy on Appointment of Authorized Member Representatives, and the form for doing so, may be accessed through our website at https://healthplans.providence.org/members/understanding-plans-benefits/benefit-basics/forms/. The policy does not apply to an attorney at law retained by you directly to represent your interests with respect to your benefits, but does apply to attorneys who represents a medical service provider whose services are a part of the claim in issue.
3. HOW TO USE YOUR PLAN

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

This section describes how to use this Plan and how benefits are applied. The level of benefits for Covered Services is shown in the Benefit Summary and described in section 4 of this document.

3.1 MEDICAL HOMES

Medical Homes have a special agreement with Providence Health Plan to provide and manage your health care. This means that not all Network Providers and Facilities are Medical Homes. Please refer to the Provider Directory for a listing of designated Connect Medical Homes. The Provider Directory can be found at our website at ProvidenceHealthPlan.com. You may also call Customer Service for assistance or to request a printed Provider Directory.

3.1.1 Choosing or Changing a Medical Home

Upon joining this Plan, you and each of your enrolled Family Members must choose a Medical Home as soon as possible. There are many Medical Homes to choose from. You and your covered Dependents may choose the same or different Medical Homes, depending on your preferences and needs.

Once you have chosen a Medical Home, you must communicate your Medical Home selection to Providence Health Plan before receiving services:

- **Phone:** Call Customer Service at 503-574-7500 or 800-878-4445, Monday through Friday, 8 a.m. to 5 p.m.
- **Mail:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com. Mail your completed form to:
  
  Providence Health Plan
  Attn: Customer Service
  P.O. Box 4327
  Portland, OR  97208-4327
- **Email:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com. Email your completed form to phpcustomerservice@providence.org.
- **Fax:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com. Fax your completed form to 503-574-8155.

If you decide to change your Medical Home selection for yourself or any of your Enrolled Family Members during the Plan year, you must communicate such change in your Medical Home selection to Providence Health Plan by using any of the notification methods listed above.

**If you do not communicate your selection or change in selection to Providence Health Plan before seeking services, your services may not be covered.**

**Advantages of Using a Medical Home**

- Your Medical Home will work with Providence Health Plan to arrange for any Medical Home Referral or Prior Authorization requirements that may be necessary for certain Covered Services. For more information on Prior Authorization, see section 3.6.
- Your Medical Home will coordinate care, when necessary, with a wide variety of high quality Network Providers to help you with your health care needs.
3.1.2 Indian Health Services Providers
Native American Indian and Alaskan Native Members may also access Covered Services from Indian Health Services (IHS) facilities at no greater cost than if the Services were accessed from a Medical Home. For a list of IHS facilities, please visit the IHS website at www.ihs.gov, or contact the regional IHS office at:

Portland Area Indian Health Service
1414 NW Northrup St., Ste. 800
Portland, OR 97209
Telephone: 503-414-5555

3.2 THE ROLE OF A MEDICAL HOME PRIMARY CARE PROVIDER
To encourage optimum health, we promote wellness and preventive care. We also believe wellness and overall health is enhanced by working closely with one physician or provider – your Medical Home Primary Care Provider. Your Medical Home Primary Care Provider can provide most of your care and, when necessary, will coordinate care with other providers in a convenient and cost-effective manner.

3.2.1 Medical Home Primary Care Providers
A Medical Home Primary Care Provider is a Qualified Practitioner 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 Member’s continuing medical care by serving as case manager. Members may choose a Qualified Practitioner specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women’s health care as their Medical Home Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Medical Home Primary Care Provider.

Medical Home Primary Care Provider 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 Medical Home Primary Care Providers offer maternity care and minor outpatient surgery as well.

**IMPORTANT NOTE:** Medical Home Primary Care Providers have a special agreement with us to serve as a case manager for your care. This means not all of our Medical Home Providers with the specialties listed above are Medical Home Primary Care Providers. Please see our online Provider Directory for a listing of designated Medical Home Primary Care Providers or call your Customer Service team to obtain a paper copy.

3.2.2 Established Patients with Primary Care Providers
If you and your family already see a provider, you may want to check the provider directory to see if your provider is a Medical Home Primary Care Provider for Providence Health Plan. If your provider is participating with us as a Medical Home, let his or her office know you are now a Providence Health Plan Connect Member.

3.2.3 Changing Your Medical Home Primary Care Provider
You are encouraged to establish an ongoing relationship with your Medical Home Primary Care Provider. If you decide to change your Medical Home Primary Care Provider, please remember to have your medical records transferred to your new Medical Home Primary Care Provider.
3.2.4 Office Visits

Medical Home Primary Care Providers
We recommend you see your Medical Home Primary Care Provider for all routine care and call your Medical Home Primary Care Provider first for urgent or specialty care. If you need medical care when your Medical Home Primary Care Provider is not available, another provider within your Medical Home may treat you and/or refer you to another Network Provider for treatment.

Other Providers (Specialists)
Your Medical Home Primary Care Provider will discuss with you the need for diagnostic tests or other specialist services; and may also refer you to a network specialist for your condition.

Your Medical Home will then be able to coordinate your care and share important medical information with your specialist. With a Medical Home Referral, you can access specialist Covered Services from Network Providers.

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

Alternative Care Providers
Your Plan includes coverage for office visits to naturopaths, chiropractors, and acupuncturists, as listed in your Benefit Summary. See section 12 for the definition of Alternative Care Provider. For coverage of chiropractic manipulation and acupuncture, see sections 4.12.11, 4.12.12 and your Benefit Summary.

3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS
Providence Health Plan may approve and provide reimbursement for Out-of-Network Qualified Practitioners and facilities. Benefits for Covered Services by an Out-of-Network Provider will be provided as shown in the Benefit Summary when we determine in advance, in writing, that the Out-of-Network Provider possesses unique skills which are required to adequately care for you and are not available from Network Providers.

Under no circumstances (with the exception of Emergency and Urgent Care) will we cover Services received from an Out-of-Network Provider/Facility unless we have Prior Authorized the Out-of-Network Provider/Facility and the Services received.

IMPORTANT NOTE: Your Plan only pays for Covered Services received from approved, Prior Authorized Out-of-Network Providers at Usual, Customary, and Reasonable rates (UCR) (see Section 12, Definitions). If an Out-of-Network Provider charges more than the UCR rates allowed under you Plan, that provider may bill you directly for the additional amount that is not covered by your Plan. That amount is in addition to any Deductible, Copayment, or Coinsurance for which you may be responsible, and does not accrue to your Out-of-Pocket Maximum.

If you choose to receive Covered Services from an approved, Prior Authorized Out-of-Network Provider, those Services are still subject to the terms of this Contract. Providence Health Plan will only pay for Medically Necessary Covered Services. No matter what type of provider you see, the treatments, supplies, and medications excluded by this Contract are not covered.
It is important for you to understand that Providence Health Plan has not assessed the provider’s credentials or quality; nor has Providence Health Plan reviewed and verified the Out-of-Network Provider’s qualifications and history for information such as: relevant training, licensure, certification, and/or registration to practice in a health care field, and academic background. Additionally, the Out-of-Network Provider will not have been assessed by Providence Health Plan to verify that the provider meets certain criteria relating to professional competence and conduct and as such is not guaranteed to follow your benefit plan, rules, regulations, or guidelines with regard to standards of care nor standards of documentation and billing.

**Prescription Drugs must be purchased at one of our Network Pharmacies** (see section 4.14). A list of our Network Pharmacies is available online at ProvidenceHealthPlan.com. You also may contact Customer Service if you need help locating a Network Pharmacy near you or when you are away from your home. See your Benefit Summary for details on your Deductible, Copayment and Coinsurance, if applicable, and on how to use this benefit.

**Payment for Out-of-Network Physician/Provider Services (UCR)**

If we have approved an Out-of-Network Provider and if the Services provided are Medically Necessary Covered Services, we will provide payment to Out-of-Network Providers according to Usual, Customary and Reasonable (UCR) charges. 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. See section 12 for the definition of UCR.

You will be responsible for costs that are not covered or allowed by your Out-of-Network benefits as shown in the following example (amounts shown are only estimates of what may apply).

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

Thus, you may incur significantly larger out-of-pocket costs, perhaps a multiple of what would have applied, if you use Out-of-Network Physicians or Providers.

**Payment for Covered Services Provided Before Disposition of Criminal Charges**

If you are in the custody of an Oregon state or local corrections agency pending the disposition of criminal charges brought by an Oregon county, we will reimburse the custodial county for the costs of Covered Services or supplies rendered before the disposition of charges, in an amount that is no less than 115 percent of the Medicare rate for the service or supply, except for renal dialysis which will be reimbursed in accordance with the terms of the Plan for Out-of-Network dialysis providers.

The following Services and Supplies are excluded from coverage under this section:

- Diagnostic tests or health evaluations required by the corrections agency, as a matter of course, for all individuals who are in the custody of the county pending the disposition of charges;
- Hospital and ambulatory surgical center services, except as rendered by an in-network provider.
3.4 MOVING INTO OR OUT OF THE SERVICE AREA

If you or a Family Member permanently moves into or out of the Service Area, you must immediately notify us and your Employer as such a move may affect your benefits or coverage under this Personal Option Plan. We will determine how this move affects your coverage and will inform you of any changes. If you have Dependent(s) who move in or out of our Service Area, a Change of Status form for those Dependent(s) must be completed and returned to us as soon as possible. This form can be obtained from us or from your Employer. See section 8.3.1 for more information.

3.5 NOTICE OF PROVIDER TERMINATION

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

3.6 PRIOR AUTHORIZATION

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

Services received from Medical Homes or with a Medical Home Referral:
When Services are received from a Medical Home or from a Network Provider through a Medical Home Referral, the Provider is responsible for obtaining Prior Authorization.

Services received from Out-of-Network Providers:
When Services are received from an Out-of-Network Provider, the Member is responsible for obtaining Prior Authorization. You or your provider must contact us to obtain Prior Authorization. See section 3.3 for additional information about receiving care from an Out-of-Network Provider.

Services requiring Prior Authorization:
- All inpatient admissions to a Hospital (not including emergency room care), Skilled Nursing Facility or a rehabilitation facility, all emergency hospitalizations (we need to be notified within 48 hours, or as soon as reasonably possible) and all Hospital and birthing center admissions for maternity/delivery Services;
- All outpatient surgical procedures;
- All Travel Expense reimbursement as provided in section 3.7;
- All inpatient, residential and day, intensive outpatient, or partial hospitalization treatment Services for Mental Health and Chemical Dependency as provided in sections 4.10.1 and 4.10.3;
- All Applied Behavior Analysis as provided in section 4.10.2;
- All Human Organ/Tissue Transplant Services as provided in section 4.13;
- All Restoration of Head/Facial Structures; Limited Dental Services as provided in section 4.12.6;
- All High Tech Imaging, including PET, CT, CTA, MRI and MRA, Nuclear Cardiac Study Services, and echocardiography Services as provided in section 4.4.1;
- All Sleep Study Services as provided in section 4.4.2;
- Certain Home Health Care Services as provided in section 4.11;
- Certain Hospice Services as provided in section 4.11;
- Certain Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment as provided in section 4.9;
- All outpatient hospitalization and anesthesia for dental Services as provided in section 4.12.6;
• All Services for Genetic Testing as provided in section 4.12.1;
• Certain medications, including certain immunizations, received in your Provider’s office as provided in sections 4.3.5 and 4.1.2;
• Certain Prescription Drugs specified in our Formulary as provided in section 4.14; and
• Certain infused Prescription Drugs administered in a hospital based infusion center as provided in section 4.7.1.

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

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

**Prior Authorization Requests for Out-of-Network Services:**
The Member or the Out-of-Network Provider must call us at 1-800-638-0449 to obtain Prior Authorization. Please have the following information ready when calling to request a Prior Authorization:

- The Member’s name and date of birth.
- The Member’s Providence Health Plan Member number and plan number (these are listed on your Member ID card).
- The Provider’s name, address and telephone number.
- The name of the Hospital or treatment facility.
- The scheduled date of admission or date Services are to begin.
- The Service(s) to be performed.

### 3.7 TRAVEL EXPENSE REIMBURSEMENT

Subject to Prior Authorization, if you are unable to locate a Network Provider to provide Medically Necessary Covered Services for your specific condition within 50 miles of your home, the Plan will reimburse your travel expense to the nearest Network Provider within 300 miles of your home. Reimbursement will be based on the federal medical mileage reimbursement rate in effect on the date of service. Travel expense reimbursement is limited to $1,500 per Calendar Year. If an overnight stay is required, food and lodging are reimbursable up to $150 per diem (per day). Per diem expenses apply to the $1,500 travel expenses reimbursement maximum. (Note: Transplant Covered Services include a separate travel expense benefit; see section 4.13.1).

### 3.8 MEDICAL COST MANAGEMENT

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

We may use or share your information with others to help manage your health care. For example, we might talk to your Qualified Practitioner to suggest a disease management or wellness program that could improve your health.

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

- Be Medically Necessary;
- Have your knowledge and agreement while receiving the Service;
- Be prescribed and approved by your Qualified Practitioner; and
- Offer a medical therapeutic value at least equal to the Covered Service that would otherwise be performed or given.

The Plan’s coverage of a Substituted Service for any Member does not obligate Providence Health Plan to:

- Cover a Substituted Service for any other Member;
- Continue to cover a Substituted Service beyond the term of the agreement between Providence Health Plan and the Member; or
- Cover any Substituted Service for the Member, other than as specified in the agreement between Providence Health Plan and the member.

Substituted Services that satisfy the requirements of this section are Covered Services for all purposes under this Plan.

We may disallow a Substituted Service at any time by sending a 30-day advance written notice to you and your Qualified Practitioner.

### 3.8.1 Coverage of New Technology and New Application of Existing Technology

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

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

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

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

- Technology must improve health outcomes. The beneficial effects must outweigh any harmful effects on health outcomes. It must improve the length of life, ability to function or quality of life.
- Technology must be as beneficial as any established alternative. It should improve the net health outcome as much, or more, than established alternatives.
- Application of technology must be appropriate, in keeping with good medical standards, and useful outside of investigational settings.
- Technology must meet government approval to market by appropriate regulatory agency as applicable.
- Criteria must be supported with information provided by well-conducted investigations published in peer-reviewed journals. The scientific evidence must document conclusions that are based on established medical facts.
- Opinions and evaluations of professional organizations, panels, or technology assessment bodies are evaluated based on the scientific quality of the supporting evidence.
Technology Evaluation Process
A committee of medical directors with physician specialist advisors evaluates all new technology and
determines coverage based on evidence for safety and efficacy. The committee relies upon a thorough
review of pertinent medical literature and utilizes national technology review services which provide
independent analysis of a new technology.

Expedited Review
Requests for coverage of new technology may occur before formal policy has been developed. In
these cases, an expedited review is implemented and a decision made on a case-by-case basis. This is
separate and distinct from the problem resolution procedure set forth in section 7.

3.9 MEDICALLY NECESSARY SERVICES
We believe our Members are entitled to comprehensive medical care within the standards of good
medical practice. Our medical directors and special committees of Network Providers determine
which Services are Medically Necessary, as defined in section 12. Services that do not meet
Medically Necessary criteria will not be covered.

• Example: Your provider suggests a treatment using a machine that has not been approved
  for use in the United States. We probably would not pay for that treatment.
• Example: You go to a hospital emergency room to have stitches removed, rather than wait
  for an appointment in your doctor’s office. We would not pay for that visit.
• Example: You stay an extra day in the hospital only because the relative who will help you
during recovery can’t pick you up until the next morning. We may not pay for the extra day.

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

3.10 APPROVED CLINICAL TRIALS
Benefits are provided for Covered Services directly related to a Member’s participation in an
Approved Clinical Trial. If your Approved Clinical Trial is available through both Network and
Out-of-Network providers, Providence will require you to participate through a Network Provider.

Covered Services include the routine patient costs for items and services received in connection with
the Approved Clinical Trial, to the extent that the items and services are otherwise Covered Services
under the Plan.

The following costs are excluded:
• The cost of the investigational item, device or service;
• The cost of items and services provided solely to satisfy data collection and analysis needs
  and that are not used in direct clinical management; and
• The cost for a service that is clearly inconsistent with widely accepted and established
  standards of care for a particular diagnosis.

The Contract does not discriminate against a Member who participates in a clinical trial, whether or
not the trial is an Approved Clinical Trial. The Contract provides benefits for services unrelated to a
clinical trial to the extent that the services are otherwise Covered Services under this Contract.
3.11 HOW BENEFITS ARE APPLIED
Benefits are subject to the following provisions, if applicable, as specified in the Benefit Summary:
1. The Deductible;
2. The Copayment or Coinsurance amount; and
3. The benefit limits and/or maximums.

3.12 DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS
Your Plan has Deductibles and Out-of-Pocket Maximums as stated in your Benefit Summary.

Deductible amounts apply to Out-of-Pocket Maximums.

3.12.1 Understanding Deductibles
Your Deductible is the dollar amount shown in the Benefit Summary that you are responsible to pay every Calendar Year for Covered Services before benefits are provided by us. Deductible amounts are payable to your Qualified Practitioner after we have processed your claim.

Certain Covered Services, such as most In-Network preventive care, are covered without a deductible. Please see your Benefit Summary for information about these Services.

**Individual Deductible:** An Individual Deductible is the amount shown in the Benefit Summary that must be paid by a Member before the Plan provides benefits for Covered Services for that Member.

**Family Deductible:** The Family Deductible is the amount shown in the Benefit Summary that applies when two or more Family Members are enrolled in this Contract, and is the maximum Deductible that enrolled Family Members must pay. All amounts paid by Family Members toward their Individual Deductibles apply toward the Family Deductible. When the Family Deductible is met, no further Individual Deductibles will need to be met by any enrolled Family Members.

*Note:* No Member will ever pay more than an Individual Deductible before the Plan begins paying for Covered Services received from for that Member.

**Your Costs that Do Not Apply to Deductibles:** The following out-of-pocket costs do not apply towards your Individual and Family Deductibles:
- Services not covered by this Contract
- Services in excess of any maximum benefit limit.
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges.
- Copayments or Coinsurance specified as not applicable toward the Deductible in any Benefit Summary issued with this Contract.

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

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

**Family Out-of-Pocket Maximum:** Family Out-of-Pocket Maximum means the total amount of Copayments, Coinsurance and Deductible that a family of two or more must pay in a Calendar Year.
Year, as shown in the Benefit Summary, before we begin to pay 100 percent for Covered Services for enrolled Family Members. When the combined Copayment, Coinsurance and Deductible expenses of enrolled 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.

Note: Once any Family Member meets the Individual Out-of-Pocket Maximum, Providence Health Plan will begin to pay 100 percent for Covered Services for that Member.

**Your Costs that Do Not Apply to Out-of-Pocket Maximums:** The following out-of-pocket costs do not apply toward your Individual and Family Out-of-Pocket Maximums:

- Services not covered by this Contract;
- Services not covered because Prior Authorization was not obtained, as required in section 3.6;
- Services in excess of any maximum benefit limit;
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges;
- Deductibles, Copayments or Coinsurance amounts for Chiropractic Manipulation and Acupuncture Services;
- Deductibles, Copayments or Coinsurance amounts for Adult Vision; and
- Deductibles, Copayments or Coinsurance for a Covered Service if indicated in any Benefit Summary as not applicable* to the Out-of-Pocket Maximum.

**IMPORTANT NOTE:** Some Benefits are NOT eligible for 100% benefit coverage. If a Covered Service is indicated as not applying toward the Out-of-Pocket Maximum, the Copayment or Coinsurance for those Services that is shown in the Benefit Summary remains in effect throughout the Calendar Year.
4. COVERED SERVICES

This section describes Services that, when Medically Necessary and not otherwise excluded or limited, are covered under this Contract. See your Benefit Summary for the Deductibles, Copayments, Coinsurance and Out-of-Pocket Maximums that apply to Covered Services.

Benefits and Plan provisions such as Deductibles, Copayments, Coinsurances and Out-of-Pocket Maximums are listed in your Benefit Summary. You can view your Member materials by registering for a myProvidence account on our website at ProvidenceHealthPlan.com (see section 2.4). If Providence Health Plan is required by law to modify your benefits, you will be notified in writing of the changes.

This Plan provides coverage of Essential Health Benefits as required by the Patient Protection and Affordable Care Act and related legislation. See section 12 for the definition of Essential Health Benefits.

Benefits are provided for preventive care and for the treatment of illness or injury when such treatment is Medically Necessary and provided by a Qualified Practitioner as described in this section and shown in the Benefit Summary.

4.1 PREVENTIVE SERVICES

Preventive Services are covered as shown in the Benefit Summary. For preventive Women’s Preventive Health Care Services, see section 4.2.

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

- Services rated “A” or “B” by the U.S. preventive Services Task Force, http://www.uspreventiveservicestaskforce.org/Page/Name/uspsf-a-and-b-recommendations/;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children and adolescents as supported by the Health Resources and Services Administration; and
- Preventive care and screenings for women as supported by the Health Resources and Services Administration, http://www.hrsa.gov/womensguidelines/.

Note: Additional Plan provisions apply to some Services (e.g., to be covered in full, routine physical examinations and well-baby care must be received from an In-Network Provider, see section 4.1.1). If you need assistance understanding coverage for preventive Services under your Plan, please contact Customer Service at 503-574-7500.

4.1.1 Physical Examinations and Well-Baby Care

Periodic health exams and well-baby care Services are covered in full only when you received In-Network. These services are covered as stated in your Benefit Summary. Your provider will determine which tests are necessary for your physical exam according to your medical history and your current health status. More frequent exams will be covered if your provider determines that they are necessary. Vision and hearing screening services are covered when performed during a periodic health examination or well-baby care examination. See also section 4.15 for coverage of pediatric vision. In order for a child to be eligible for benefits for routine newborn baby care, the child must be properly enrolled as outlined in section 8. Ancillary Services, such as immunizations, are covered at the specified benefit level when billed by the provider.
Recommended guidelines:

Infants up to 30 months: Up to 12 well-baby visits.

Children and Adolescents:
3 years through 21 years: One exam every year.

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

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

4.1.2 Immunizations and Vaccinations
Benefits for immunizations and vaccinations are provided in accordance with accepted medical practice. Visits to your Qualified Practitioner’s office or Network Pharmacy for immunizations or injections are subject to the Copayment or Coinsurance shown in the Benefit Summary. Some immunizations may require Prior Authorization.

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

4.1.3 Prostate Screening Exams
Benefits for prostate cancer screening examinations include digital rectal examination and a prostate-specific antigen test, biennially for men 50 and older, or as recommended by your Qualified Practitioner for men designated as high risk.

4.1.4 Colorectal Screening Exams
Benefits for colorectal cancer screening examinations for Members 50 and older include:

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

Screening examinations and lab tests for Members designated as high-risk are covered as recommended by your Qualified Practitioner.

For members age 50 and older:
All Services for colorectal cancer screenings and exams are covered in full, including prescription drug bowel prep kits, as listed in our formulary.

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

For all Members, non-preventive colonoscopy and sigmoidoscopy procedures provided to treat health conditions (injury, illness or disease) are covered under your Outpatient patient benefits, as shown in your Benefit Summary.
4.1.5 Preventive Services for Members with Diabetes
Preventive Covered Services for Members diagnosed with either insulin dependent or non-insulin dependent diabetes mellitus include:

- A dilated retinal exam by a qualified eye care specialist every Calendar Year;
- A glycosylated hemoglobin (HbA1c) test, a urine test to test kidney function, blood test for lipid levels as appropriate, a visual exam of mouth and teeth (dental visits are not covered), foot inspection, and influenza vaccine by a Qualified Practitioner every Calendar Year; and
- A pneumococcal vaccine every five years.

4.1.6 Diabetes Self-Management Education Program
Benefits are paid in-full for diabetes self-management education programs associated with the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes as prescribed by a Qualified Practitioner. “Diabetes self-management program” means one program of assessment and training after diagnosis as well as assessment and training upon a material change of condition, medication or treatment. All services must be received from licensed providers and facilities, practicing within scope of license.

4.1.7 Nutritional Counseling
Nutritional counseling is covered when Medically Necessary, shown in your Benefit Summary. Fasting and rapid weight loss programs are not covered.

4.1.8 Tobacco Use Cessation Services
Coverage is provided 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 by calling Customer Service at 503-574-7500 or 800-878-4445 and online at ProvidenceHealthPlan.com (select “search” and enter “tobacco cessation”).

4.2 WOMEN’S PREVENTIVE HEALTH CARE SERVICES
Women may choose to receive Women’s Preventive Health Care Services from a Primary Care Provider or a Women’s Health Care Provider. Women’s Health Care Providers include physicians specializing in obstetrics, some Primary Care Providers and naturopaths (if they are licensed to provide the services), physician assistants and nurse practitioners specializing in women’s health care, certified nurse midwives, and licensed direct entry midwives.

4.2.1 Gynecological Examinations
Benefits for gynecological examinations include breast, pelvic and Pap examinations once every Calendar Year or more frequently if the Member is designated high risk. Family planning Services are separate (see section 4.3.3). Benefits also include follow-up exams for any medical conditions discovered during an annual gynecological exam that require additional treatment.

4.2.2 Mammograms
Mammograms are covered for women 40 years of age and over once every Calendar Year. If the Member is designated high risk, mammograms are provided at the recommendation of your Qualified Practitioner or Women’s Health Care Provider.
4.2.3 Breastfeeding Counseling and Support
Coverage for lactation counseling is provided when Medically Necessary as determined by the Qualified Practitioner. Benefits include coverage in full for breast pump equipment and supplies when rented or purchased through our Network Medical Equipment Providers.

4.2.4 Family Planning Services
Benefits include counseling, exams, and services for voluntary family planning.

Services and supplies are covered as required by the Patient Protection and Affordable Care Act of 2010 and related legislation; and include, but are not limited to:

- Intrauterine device (IUD) insertion and removal;
- Medical exams and consultation for family planning;
- Depo-Provera to prevent pregnancy;
- Diaphragm devices;
- Removal of implantable contraceptives; and
- Oral contraceptives (birth control pills) listed in our Formulary.

Services are covered in full and must be received from Network Providers and Facilities or purchased from Network Pharmacies.

For coverage of tubal ligation, see Elective Sterilization, section 4.12.9.

4.3 PROVIDER SERVICES

4.3.1 Office Visits, Inpatient and Outpatient Hospital Visits, and Home Visits
Office visits, inpatient and outpatient Hospital visits and home visits with a Qualified Practitioner are covered as shown in your Benefit Summary. Copayments and Coinsurances, as shown in your Benefit Summary, apply to all provider visits except those that: (a) are part of a course of maternity care; (b) are for conditions for which this Contract contains a separate and specific Copayment or Coinsurance amount; or (c) are ancillary to the visit and are billed by the Qualified Practitioner. Some services provided by your Qualified Practitioner during you visit may result in additional Member financial responsibility.

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

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

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

4.3.2 Virtual Visits
The Plan provides coverage for Virtual Visits with Network Providers using secure internet technology:
• **Phone and Video Visits**
  Phone and Video Visits are covered as shown in your Benefit Summary. All Phone and Video Visits must be Medically Necessary and received from Participating Providers. Not all Participating Providers are contracted with us to provide Phone and Video Visits. Participating Providers who are authorized to provide Phone and Video Visits have agreed to use secure internet technology approved by us to protect your information from unauthorized access or release.

• **Web-direct Visits**
  Web-direct visits for common conditions such as cold, flu, sore throat, allergy, earache, sinus pain, or UTI are covered as shown in your Benefit Summary. The Member completes a questionnaire to describe the common condition. The questionnaire is reviewed by a Network Provider who makes a diagnosis and sends a treatment plan back to the Member. If needed, a prescription is sent to the Member’s pharmacy. All Web-direct Visits must be Medically Necessary and received from authorized Network Providers.

4.3.3 E-visits

E-visits are covered in full and must be received from Network Providers. Not all Network Providers offer E-visits. Medical doctors (M.D.), doctors of osteopathy (D.O.), nurse practitioners (N.P.) and physician assistants (P.A.) are the only categories of providers approved for E-visits. Network Providers who are authorized to provide E-visits have agreed to use appropriate Internet security technology, approved by us, to protect your information from unauthorized access or release. To be eligible for the E-visit benefit, you must have had at least one prior office visit with your Network Provider within the last 12 months.

Covered E-visits include, but are not limited to:

- Communications of a new or existing diagnosis or treatment when the equivalent Service received through an office visit would have led to a claims submission to be covered by us;
- Communications by the Network Provider about the management of complex chronic conditions that require extensive education and ongoing monitoring;
- Communications of treatment for relapses of a previous condition that involve extended dialogue and significant physician time and judgment;
- Discussion of lab results that require significant changes in medication or further testing; and
- Extended counseling when person-to-person contact would involve an unwise delay.

Examples of e-mail and telephone communications that do not qualify as E-visits or Telephone Consults include, but are not limited to:

- Renewing prescriptions;
- Scheduling tests;
- Scheduling appointments;
- Reporting normal test results;
- Recommending a referral to another physician;
- A consultative message exchange from a patient who is seen in-person immediately afterward as a result of the consultative message;
- A brief follow-up of an office visit, medical procedure or other treatment to confirm stable condition;
- A brief discussion to confirm stability of a chronic problem and continuity of present management of the problem;
- All communications in connection with Mental Health or Chemical Dependency Services (as provided in section 4.10).
4.3.4 Telemedical Services

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

- Is Medically Necessary;
- Is provided by a Qualified Practitioner;
- Is determined to be safely and effectively provided using synchronous two-way interactive video conferencing according to generally accepted health care practices and standards; and
- The application and technology used to provide the Telemedical Service meet all standards required by state and federal laws governing the privacy and security of protected health information.

For Members utilizing Telemedical Services for the treatment of diabetes where one of the participants is a representative of an academic health center, coverage is provided when Services are delivered through a two-way electronic communication. This includes, but is not limited to, video, audio, Voice over Internet Protocol, or transmission of telemetry, that allows a health professional to interact with the Member, a parent or guardian of a Member or another health professional on a Member’s behalf, who is at an originating site.

4.3.5 Allergy Shots, Allergy Serums, Injectable and Infused Medications

Allergy shots, allergy serum, injectable and infused medications, and total parenteral nutrition (TPN) received in your Provider’s office are covered as shown in your Benefit Summary. Therapy and testing for treatment of allergies including, but not limited to, Services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment are covered only when such therapy or testing is approved by The American Academy of Allergy and Immunology, or The Department of Health and Human Services or any of its offices or agencies. Some injectable medications may require Prior Authorization. See section 4.7.1 for coverage of infusion at Outpatient Facilities.

4.3.6 Administration of Anesthesia and Surgical Procedures

Benefits include the administration of anesthesia and surgical procedures, including assistant surgeon and post-operative care.

4.3.7 Immediate Care

Immediate Care is an extension of your Primary Care Provider’s office, and provides additional access to 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, like periodic health exams and well-baby care, should be delayed until you can be seen by your Primary Care Provider.

Whenever you need immediate care or Urgent Care, call your Primary Care Provider first. Your Primary Care Provider or the provider-on-call is always available, day or night. He or she may either suggest that you be seen at your Primary Care Provider’s office, or direct you to an immediate care center, Urgent Care, or emergency care facility. See section 4.5 for coverage of Emergency Care and Urgent Care Services.

Please be prepared to pay the Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are also responsible for the applicable Copayment/Coinsurance shown in the Benefit Summary for any ancillary Services received, such as lab tests and X-rays, billed by the Immediate Care Provider.

4.3.8 Retail Health Clinic

Coverage is provided as shown in the Benefit Summary for Covered Services obtained at Retail Health Clinics. Retail Health Clinics can provide diagnosis and treatment services for uncomplicated...
minor illnesses and injuries, like sore throats, ear aches, and sprains. Routine care, like periodic health exams and well-baby care, should be delayed until you can be seen by your Primary Care Provider. All Covered Services must be Medically Necessary and appropriate and received from Qualified Practitioners. Not all services are available at Retail Health Clinics.

4.4 DIAGNOSTIC SERVICES
Coverage is provided as shown in your Benefit Summary for Diagnostic Services.

4.4.1 Diagnostic Pathology Radiology Tests and Diagnostic Procedures
Benefits are as shown in the Benefit Summary and include inpatient and outpatient diagnostic pathology (lab), high tech imaging (such as PET, CT, MRI and MRA), radiology (X-ray) tests, echocardiography, and other Medically Necessary diagnostic procedures. Covered Services include contrast materials (dyes) that may be required for a diagnostic procedure.

4.4.2 Sleep Study Services
Benefits are as shown in the Benefit Summary and include coverage of Medically Necessary polysomnography (PSG). PSG is an overnight sleep test performed at home or in a sleep laboratory. The test is used to confirm a sleep disorder and to determine the appropriate treatment. Services must be Prior Authorized.

The following diagnostics are excluded: actigraphy, daytime nap polysomnography, cephalographic or tomographic X-rays for diagnosis or evaluation of an oral device, and acoustic pharyngometry.

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

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

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

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

Definitions:
“Emergency Medical Condition” is a medical condition that manifests itself by acute symptoms of sufficient severity that a prudent layperson, possessing an average knowledge of health and medicine, would reasonably expect that failure to receive immediate medical attention would:

- Result in serious impairment to bodily functions;
- Result in serious dysfunction of any bodily organ or part; or
• Place the health of a person, or an unborn child in the case of pregnant woman, in serious jeopardy;
• With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which transfer may pose a threat to the health or safety of the woman or the unborn child.
• That is a behavioral health crisis.

“Emergency Services” means, with respect to an Emergency Medical Condition:
• An emergency medical screening exam, or behavioral health assessment that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
• Such further medical examination and treatment as are required under the Emergency Medical Treatment and Active Labor Act (42 U.S.C. 1395dd) to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at the Hospital.

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

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

Call your Primary Care Provider any time, any day of the week. Your Primary Care Provider or the provider-on-call will tell you what to do and where to go for the most appropriate care.

Please be prepared to pay your Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are responsible for the Copayment/Coinsurance for each Hospital emergency room visit. If you are admitted to the Hospital from the emergency room, your emergency Services Copayment/Coinsurance does not apply and all Services are subject to the Inpatient Services benefit shown in your Benefit Summary.

The Contract does not pay for emergency room treatment for medical conditions that are not medical emergencies. Do not go to the emergency room for care that should take place in your provider’s office. Routine care for sore throats, common colds, follow-up care, and prescription drug requests are not considered to be emergencies.

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

**4.5.3 Emergency Eye Care Services**
Covered Services include the initial care for Emergency Medical Conditions involving injury or illness to a Member’s eye(s). Members may receive Services directly from an optometrist or ophthalmologist or a Hospital emergency room.
4.5.4 Emergency Detoxification Services
Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a Chemical Dependency treatment program, as stated in section 4.9.2, at the time Services are received. Prior Authorization is not required for emergency treatment; however, we or our authorizing agent must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to a Network Provider for continued inpatient care, the cost of Medically Necessary transportation will be covered. Continuing or follow-up care is not a Covered Service unless Prior Authorized by us or our authorizing agent.

4.5.5 Urgent Care
Urgent care is treatment you need right away for an illness or injury that is not non-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 Primary Care Provider first. Your Primary Care Provider or the provider-on-call is always available, day or night. He or she may either suggest that you come to the office or go to an emergency room or urgent care center. If you can be treated in your provider’s office or at a network urgent care center your out-of-pocket expense will usually be lower.

Please be prepared to pay the Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are also responsible for the applicable Copayment/Coinsurance shown in the Benefit Summary for any ancillary Services received, such as lab tests and X-rays billed by the Qualified Provider.

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

Not all Out-of-Network facilities will file a claim on a Member’s behalf. If you receive urgent care Services from an Out-of-Network facility, you must submit a claim if the facility or provider does not submit it for you. See section 6.1.1.

4.6 INPATIENT HOSPITAL AND SKILLED NURSING FACILITY SERVICES
Coverage is provided as shown in your Benefit Summary for Hospital and Skilled Nursing Facility Services. 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.
4.6.1 Inpatient Hospital Services

Benefits are provided as shown in the Benefit Summary.

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

Only Medically Necessary Hospital Services are covered. Covered inpatient Services received in a Hospital are:

- Acute (inpatient) care;
- A semi-private room (unless a private room is Medically Necessary);
- Coronary care and intensive care;
- Isolation care; and
- Hospital services and supplies necessary for treatment and furnished by the hospital, such as use of the 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 you medically appropriate length of stay. If you choose to stay in the Hospital longer than you physician advises, you will be responsible for the cost of additional days in the Hospital.

4.6.2 Skilled Nursing Facility

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

4.6.3 Inpatient Rehabilitative Care

Benefits are provided for physical, occupational and speech therapy Covered Services as shown in the Benefit Summary for inpatient rehabilitative care to restore or improve lost function following illness or injury. If a Member is hospitalized when rehabilitative Services begin, rehabilitative benefits will begin on the day treatment becomes primarily rehabilitative. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member’s condition. Benefits are subject to the durational limits stated in the Benefit Summary. (See section 4.7.2 for coverage of Outpatient Rehabilitative Services.)

4.6.4 Inpatient Habilitative Care

Coverage is provided, as shown in the Benefit Summary, for Medically Necessary inpatient habilitative care. If a Member is hospitalized when habilitative Services begin, habilitative benefits will begin on the day treatment becomes primarily habilitative. All Services must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. (See section 4.7.3 for coverage of Outpatient Habilitative Services.)

4.6.5 Observation Care

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

4.7 OUTPATIENT SERVICES

4.7.1 Outpatient Services: Surgery, Dialysis, Infusion, Chemotherapy and Radiation Therapy

Benefits are provided as shown in the Benefit Summary and include Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider’s office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, radiation oncology, and therapeutic procedures as ordered by your Qualified Practitioner. We may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, we will not Prior Authorize the Services. For additional information about Prior Authorization, see section 3.6.

Covered Services under these benefits do not include Services for Outpatient Rehabilitative Services. See section 4.7.2 for those Services.

4.7.2 Outpatient Rehabilitative Services

Benefits are included for outpatient physical, occupational and speech therapy Covered Services provided by a physician or licensed/registered therapist, as stated in the Benefit Summary, to restore or improve lost function following illness or injury. Additional visits will be covered when criteria are met for the following conditions:

- Neurological disorders (e.g., stroke, spinal cord injury, head injury, pediatric neurodevelopmental disorders); and
- Pervasive developmental disorders.

Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member’s condition and are subject to the visit benefit maximum stated in the Benefit Summary. A visit is considered a treatment with one provider (e.g., if you see a physical therapist and a speech therapist the same day at the same facility, it counts as two visits as you have received treatment from two providers).

Covered Services under this benefit do NOT include:

- Chiropractic adjustments and manipulations of any spinal or bodily area;
- Exercise programs;
- Rolfing, polarity therapy and similar therapies; and
- Rehabilitation services provided under an authorized home health care plan as stated in section 4.8.11.

See section 4.6.3 for coverage of Inpatient Rehabilitative Services.

4.7.3 Outpatient Habilitative Services

Coverage is provided, as shown in the Benefit Summary, for Medically Necessary outpatient habilitative Services for maintenance, learning or improving skills and function for daily living. Additional visits will be covered when criteria are met for the following conditions:

- Neurological disorders (e.g., stroke, spinal cord injury, head injury, pediatric neurodevelopmental disorders); and
• Pervasive developmental disorders.

All Services must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. See section 4.6.4 for coverage of Inpatient Habilitative Services.

4.8 MATERNITY SERVICES

Your benefits include coverage for comprehensive maternity care.

Your Benefit Summary lists your Member costs (Deductible, Copayment and/or Coinsurance) per pregnancy for prenatal office visits, postnatal office visits and delivery Provider Services. These Member costs do not apply to other Covered Services, such as lab and imaging, which you may receive for your maternity care. The specific Coinsurance or Copayment for each of these services will apply instead. Please refer to your Benefit Summary for details.

Women may choose to receive Maternity Services from a Primary Care Provider or a Women’s Health Care Provider. Women’s Health Care Providers include physicians specializing in obstetrics, some Personal Care Providers and naturopaths (if they are licensed to provide obstetrical services), physician assistants and advanced registered nurse practitioners specializing in women’s health, certified nurse midwives, and licensed direct entry midwives.

Covered Services include:

• Prenatal care.
• Delivery at an approved facility or birthing center.
• Postnatal care, including complications of pregnancy and delivery.
• Emergency treatment for complications of pregnancy and unexpected pre-term birth.
• Newborn nursery care* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within time frames outlined in Newborn Eligibility and Enrollment, section 8.3.

*Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit. See section 8.3 regarding newborn eligibility and enrollment.

IMPORTANT NOTE: Maternity Services for a Member who is serving as a surrogate parent are covered, except to the extent that such services are payable under the surrogate parenting contract or agreement.

The services of a lay, unlicensed direct entry, certified professional or any other unlicensed midwife are not covered.

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

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

*Diabetes coverage during pregnancy:* During pregnancy through six weeks postpartum, the Plan provides coverage in full for diabetes services, medications, and supplies when received In-Network.

### 4.9 MEDICAL SUPPLIES, MEDICAL APPLIANCES, PROSTHETIC AND ORTHOTIC DEVICES, DURABLE MEDICAL EQUIPMENT (DME), HEARING AIDS, AND WIGS

Benefits for medical supplies, medical appliances, prosthetic and orthotic devices, Durable Medical Equipment (DME) and hearing aids are provided as shown in the Benefit Summary when required for the standard treatment of illness or injury. We may authorize the purchase of an item if we determine the cost of purchasing an item would be less than the overall rental of the item. Services must be prescribed by a 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 we determine otherwise. Repair or replacement is covered if due to normal growth processes or to a change in your physical condition due to illness or injury.

#### 4.9.1 Medical Supplies (including Diabetes Supplies)

Benefits are shown in the Benefit Summary for the following medical supplies and diabetes supplies:

1. Medically Necessary supplies as ordered by your Qualified Practitioner, including, but not limited to, ostomy supplies, prescribed needles, syringes and chem strips. Non-sterile examination gloves used by you or your caregiver are NOT a covered medical supply.
2. Diabetes supplies, such as needles, syringes, lancets and test strips, may be purchased through Providence Health Plan participating medical supply providers or under this benefit at Network Pharmacies. Unless there is a medical exception on file, diabetes test strips are limited to 100 test strips per month for insulin dependent Members and 100 test strips every three months for non-insulin dependent Members. See section 4.9.4 for coverage of diabetic equipment such as glucometers and insulin pump devices.
3. Medically Necessary medical foods for supplementation or dietary replacement including non-prescription elemental enteral formula for home use, when determined to be Medically Necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition. Medical foods are also covered for the treatment of Inborn Errors of Metabolism, as described in section 4.12.2. Medical foods do not include total parenteral nutrition (TPN), which is covered under section 4.3.5.

#### 4.9.2 Medical Appliances

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

1. Casts, braces and supportive devices when used in the treatment of medical or surgical conditions in acute or convalescent stages or as immediate post-surgical care.
2. Initial and replacement contact lenses, intraocular lenses, prescription lenses or standard frame glasses, when required as a result of injury, illness or surgery, such as, but not limited to, cataract, corneal transplant surgery or for the treatment of keratoconus.
3. Rental of an oxygen unit used in the home for Members with significant hypoxemia who are unresponsive to other forms of treatment. The benefit is limited to three months from the initial date of Service unless there is clinical evidence of the need to continue.
4. Removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are subject to the benefit maximum stated in the Benefit Summary.
5. Medical devices that are surgically implanted into the body to replace or aid function (including bilateral cochlear implants). If you receive a procedure to implant a medical device, you will be responsible for any Copayment or Coinsurance for the medical device in addition to any Copayment or Coinsurance for the procedure.

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

4.9.3 Prosthetic and Orthotic Devices

Benefits are provided for prosthetic and orthotic devices as shown in the Benefit Summary. Coverage is limited to those prosthetic and orthotic devices that are Medically Necessary and included in the Medicare fee schedule for Durable Medical Equipment, Prosthetics, Orthotics and Supplies. Covered Services include rigid or semi-rigid devices used for supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck or an artificial limb device or appliance designed to replace in whole or in part an arm or a leg; breast implants following mastectomy; artificial eyes; and maxillofacial prosthetic devices for the restoration and management of head and facial structures. (For coverage of removable custom shoe orthotics, see section 4.9.2.)

4.9.4 Durable Medical Equipment (DME)

Benefits are provided for DME as shown in the Benefit Summary. Covered Services may include Medically Necessary equipment such as a hospital bed, non-motorized wheelchair, ventilator, and similar equipment as approved by us.

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

4.9.5 Hearing Aids

Medically Necessary external hearing aids and devices, one per ear per every four calendar years, prescribed, fitted, and dispensed by a licensed audiologist or hearing aid/instrument specialist, are covered under this Plan. “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.

Office visits for routine hearing exams and tests, including those related to the evaluation/fitting of a hearing aid, will be payable under this Plan at the office visit benefit level as shown in your Benefit Summary.

4.9.6 Wigs

The Plan will provide coverage for one synthetic wig every calendar year for Members who have undergone chemotherapy or radiation therapy at the Medical Equipment, Supplies and Devices benefit level listed in your Benefit Summary. Wigs may be purchased from any wig supplier. Wig suppliers may require Members to pay for items and submit the paid receipt to Providence Health Plan for reimbursement. For information about submitting claims, see section 6.1.1.

4.10 MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES

This Contract complies with Oregon and Federal Mental Health Parity.

4.10.1 Mental Health Services

Benefits are provided for Mental Health Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions.
Covered Services include diagnostic evaluation, individual and group therapy, inpatient hospitalization as stated in section 4.4, residential, and day, intensive outpatient, or partial hospitalization Services. All inpatient, residential, and day, intensive outpatient, or partial hospitalization treatment Services must be Prior Authorized as specified in section 3.6.

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

### 4.10.2 Applied Behavior Analysis

Benefits are provided for Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorders, subject to the following limitations:

- Services must be Medically Necessary;
- The initial screening and an individualized treatment plan must be provided by a licensed neurologist, pediatric neurologist, developmental pediatrician, psychiatrist or psychologist, who has experience or training the diagnosis of autism spectrum disorder;
- Prior authorization is received by us or our authorizing agent;
- Benefits include coverage of any other non-excluded mental health or medical services identified in the individualize treatment plan;
- Treatment must be provided by a health care professional licensed to provide ABA Services; and
- Treatment may be provided in the Member’s home or in a licensed health care facility.

Exclusions to ABA Services:

- Services provided by a family or household member;
- Services that are custodial in nature, or that constitute marital, family, or training services;
- Services that are educational or correctional that are provided by a school or halfway house or received as part of an educational or training program;
- Custodial or respite care, creative arts therapy, wilderness or adventure camps, social counseling, music therapy, neurofeedback, chelation or hyperbaric chambers;
- Services provided under an individual education plan in accordance with the Individuals with Disabilities Education Act;
- Services provided through community or social programs; and
- Services provided by the Department of Human Services or the Oregon Health authority, other than employee benefit plans offered by the department and the authority.

An approved ABA treatment plan is subject to review by us or our authorizing agent, and may be modified or discontinued if review shows that the Member receiving treatment is not making measurable clinical progress toward the goals identified in the treatment plan.

### 4.10.3 Chemical Dependency Services

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

Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, and day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by us or our authorization agent.

Prior Authorization is required for all inpatient, residential, and day, intensive outpatient, or partial hospitalization treatment Services, as specified in section 3.6.
Treatments involving the use of methadone are a Covered Service only when such treatment is part of a medically-supervised treatment program that has been Prior Authorized.

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

4.11 HOME HEALTH AND HOSPICE CARE

4.11.1 Home Health Care

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

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

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

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

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

Rehabilitation services provided under an authorized home health care plan will be covered as home health care Services.

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

4.11.2 Hospice Care

Benefits are included for hospice care as shown in the Benefit Summary and as stated in this section.

In addition, the following criteria must be met:
1. Your Qualified Practitioner certifies that you have a terminal illness with a life expectancy not exceeding six months; and
2. The Covered Services provided are reasonable and necessary for the condition and symptoms being treated.
When these criteria are met, we will provide benefits for a full range of Covered Services which a certified hospice care program is required to include. Covered Services include the following:

- 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 you and your caregivers adjust to the approaching death;
- Services provided by your Qualified Practitioner or a physician associated with the hospice program;
- Durable Medical Equipment (DME), 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 to the goals of the plan of care;
- Rehabilitation therapies provided for purposes of symptom control or to enable you to maintain activities of daily living and basic functional skills; and
- Continuous home care during a period of crisis in which you require skilled intervention to achieve palliation or management of acute medical symptoms.

Respite care is limited to Members receiving Hospice Care and is covered as shown in your Benefit Summary.

4.12 OTHER COVERED SERVICES

4.12.1 Genetic Testing and Counseling Services

Genetic testing and counseling are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature. Genetic testing requires Prior Authorization as shown in section 3.6.

4.12.2 Inborn Errors of Metabolism

We will provide benefits for Covered Services as shown in the Benefit Summary based upon the type of Services received for diagnosing, monitoring and controlling inborn errors of metabolism, including, but not limited to: phenylketonuria (PKU); homocystinuria; citrullinemia; maple syrup disease; and pyruvate dehydrogenase deficiency; that involve amino acid, carbohydrate and fat metabolism for which medically standard methods exist, including quantification of metabolites in blood, urine, or spinal fluid or enzyme or DNA confirmation in tissues. Covered Services include clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. For coverage of medical foods, see section 4.9.1.

4.12.3 Podiatry/Foot Services

Benefits include Covered Services of a podiatrist or other Qualified Practitioner and are provided as shown in the Physician/Provider Services section of the Benefit Summary. Covered Services include, but are not limited to, the fitting and follow up exam for removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are covered as stated in section 4.9.2 (Medical Appliances). Covered Services do not include routine foot care and the removal of corns or calluses, unless you have diabetes.

4.12.4 Reconstructive Surgery

Reconstructive surgery is covered for conditions resulting from trauma, infection or other diseases and for congenital deformities and anomalies if there is a resultant functional impairment. Benefits are covered as those Services listed in the Benefit Summary based upon the type of Services received. For Restoration of Head or Facial Structures; Limited Dental Services, see section 4.12.6.
4.12.5 Reconstructive Surgery of the Breast

Members who have undergone mastectomy are entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). “Mastectomy” means the surgical removal of breast tissue and breast lumps due to malignancy or suspected malignancy.

Benefits for Reconstructive Surgery of the breast are covered as those Services listed in the Benefit Summary based upon the type of Services received. Reconstructive Surgery of the breast is covered for:

- All stages of reconstruction of the involved breast following a mastectomy;
- Surgery and construction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

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

4.12.6 Restoration of Head/Facial Structures; Limited Dental Services

Covered Services are limited to those Services that are Medically Necessary for the purpose of controlling or eliminating pain, or restoring facial configuration of functions such as speech, swallowing or chewing. Medically Necessary Covered Services include restoration and management of head and facial structures, including teeth, dental implants and bridges, that cannot be replaced with living tissue and that are defective because of trauma, disease or birth or developmental deformities, not including malocclusion of the jaw.

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

Exclusions that apply to Covered Services include:

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

Outpatient Hospitalization and Anesthesia for Limited Dental Services

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

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

Dental Services are excluded, unless covered under the Pediatric Dental Benefit.
4.12.7 Self-Administered Chemotherapy
Self-administered chemotherapy agents, including oral, topical and injectable medications that are used to stop or slow the growth of cancerous cells, are covered when received from a Network retail or specialty Pharmacy.

Self-administered chemotherapy is covered under the Prescription Drug Benefit unless the Outpatient Chemotherapy coverage results in a lower out-of-pocket expense to the Member (See sections 4.7.1 and 4.14 and your Benefit Summary).

4.12.8 Biofeedback
Coverage is provided as shown in the Benefit Summary for biofeedback to treat migraine headaches or urinary incontinence. Services must be Medically Necessary and within the Qualified Practitioner’s scope of license.

4.12.9 Elective Sterilization
Coverage is provided for voluntary sterilization (tubal ligation or vasectomy). Services are covered in full and must be received from Network Providers and Facilities.

Please note: Providence Health Plan is a Catholic-sponsored health plan, and, as a matter of conscience, Providence Health and Services facilities do not offer these Services. Services are available at other Participating facilities.

4.12.10 Gender Dysphoria
Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable In-Patient or Out-Patient facility benefit. Treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for a list of services requiring Prior Authorization.

4.12.11 Chiropractic Manipulations
Coverage is provided for chiropractic manipulation as stated in your Benefit Summary. To be eligible for coverage, all chiropractic manipulation Services must be Medically Necessary and within the Qualified Practitioner’s scope of license.

4.12.12 Acupuncture
Coverage is provided for acupuncture as stated in your Benefit Summary. To be eligible for coverage, all acupuncture Services must be Medically Necessary and within the Qualified Practitioner’s scope of license.

4.13 HUMAN ORGAN/TISSUE TRANSPLANTS
A transplant is defined as a procedure or series of procedures by which an organ or tissue is either:
   1. Removed from the body of one person (the donor) and implanted in the body of another person (the recipient who is a Member); or
   2. Removed from and replaced in the same person’s body (a self-donor who is a Member).

The term transplant does not include Services related to the transfusion of blood or blood derivatives (except hematopoietic stem cells) or replacement of a cornea. Corneal replacement is covered under the applicable provider and facility surgical benefits.
4.13.1 Covered Services

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

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

Services for donors are covered when the donor is not eligible for coverage of donation Services under any other health benefit plan or government funding program. Covered Services for donors include:
1. Initial evaluation of the donor and related program administration costs;
2. Preserving the organ or tissue;
3. Transporting the organ or tissue to the transplant site;
4. Acquisition charges for cadaver or live donor;
5. Services required to remove the organ or tissue from the donor; and
6. Treatment of medical complications directly resulting from the surgery performed to obtain the organ or tissue for a period of time not to exceed 30 consecutive days following that surgery.

4.13.2 Benefits for Transplant Facility Services Provided to the Organ Recipient

The Deductible, if any, and Coinsurance or Copayment provisions of this Contract are waived, except as follows:

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

4.13.3 Benefits for Outpatient Medications

Outpatient prescription medications, including anti-rejection (immunosuppressive) drugs, are covered under the Prescription Drug Benefit and those benefits are subject to the terms and limitations of that Benefit, see section 4.14.
4.13.4 Benefits for Physician/Provider Services Provided to the Organ Recipient

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

4.13.5 Transplant Prior Authorization

(See also section 3.6.)

To qualify for coverage under this Contract, all transplant related Services, procedures, treatment protocols and facilities must be Prior Authorized, including:

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

4.13.6 Transplant Exclusions

In addition to the exclusions listed in section 5, the following exclusions apply to human organ/tissue transplants:

- Any transplant procedure performed at a transplant facility that has not been approved by us;
- Any transplant that is Experimental/Investigational, as determined by us;
- Services or supplies for any transplant that are not specified as Covered Services in this section 4.10, such as transplantation of animal organs or artificial organs;
- Services related to organ/tissue donation by a Member if the recipient is not a Member or the Member/recipient is not eligible for transplant benefits under this Contract; and
- Transplant-related travel expenses for the donor and the donor’s and recipient’s family members.

4.14 PRESCRIPTION DRUG BENEFIT

The Prescription Drug 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 Network Pharmacy pursuant to a prescription ordered by a Qualified Practitioner for use on an outpatient basis, subject to your Plan’s benefits, limitations and exclusions.

Prescription Drug Definition

The following are considered “Prescription Drugs”:

1. Any medicinal substance which bears the legend, “RX ONLY” or “Caution: federal law prohibits dispensing without a prescription”;
2. Insulin;
3. Any medicinal substance of which at least one ingredient is a federal legend drug in a therapeutic amount; and
4. Any medicinal substance which has been approved by the Oregon Health Evidence Review as effective for the treatment of a particular indication.
4.14.1 Using Your Prescription Drug Benefit

Your prescription drug benefit requires you to fill your prescriptions at a Network Pharmacy.

You have access to Providence Health Plan’s designated pharmacy network as published in our pharmacy directory.

Providence Health Plan Network Pharmacies are those pharmacies that maintain all applicable certifications and licenses necessary under state and federal law of the United States and have a contractual agreement with us to provide Prescription Drug Benefits.

Network Pharmacies are designated as retail, preferred retail, specialty and mail-order Pharmacies. To view a list of Network Pharmacies, visit our website at ProvidenceHealthPlan.com. You also may contact Customer Service at the telephone number listed on your Member ID card.

- Please present your Member ID Card to the Network Pharmacy at the time you request Services. If you have misplaced or do not have your Member ID Card with you, please ask your pharmacist to call us.
- All Covered Services are subject to the Deductible, Copayments or Coinsurance and benefit maximums listed in your Benefit Summary.
- If you choose a brand-name drug when a generic-equivalent is available, any difference in cost for Prescription Drug Covered Services will not apply to your Calendar Year Deductibles and Out-of-Pocket Maximums.
- Network Pharmacies may not charge you more than your Copayment of Coinsurance, subject to Deductible and coverage limitations. Please contact Customer Service if you are asked to pay more or if you, or the pharmacy, have questions about your Prescription Drug Benefit or need assistance processing your prescription.
- Copayments or Coinsurance are due at the time of purchase. If the cost of your Prescription Drug is less than your Copayment, you will only be charged the cost of the Prescription Drug.
- You may be assessed multiple Copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- You may purchase up to a 90 day supply of each maintenance drug at one time using a Network mail service or preferred retail Pharmacy. Not all drugs are covered for more than a 30 day supply, including compounded medications, drugs obtained from specialty pharmacies, and limited distribution pharmaceuticals. To obtain prescriptions by mail, your physician or provider can call in or electronically send the prescription, or you can mail your prescription along with your Providence Health Plan Member ID number to one of our Network mail-order Pharmacies.
  To find our Network mail-order Pharmacies, please visit our website at ProvidenceHealthPlan.com. (Not all prescription drugs are available through our mail-order pharmacies).
- Providence Health Plan will provide Members prescription synchronization services for maintenance medications. Upon Member or provider request, the Plan will coordinate with Members, providers, and the dispensing pharmacy to synchronize maintenance medication refills so Members can pick up maintenance medications on the same date. Members will be responsible for applicable Copayments, Coinsurances and Deductibles.
- Diabetes supplies and inhalation extender devices may be obtained at your Network Pharmacy. However, these items are considered medical supplies and devices and are subject to your Medical Supplies benefits, limitations and Copayments and/or Coinsurance. See section 4.9.1 and your Benefit Summary. Diabetes supplies do not include glucometers and insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.9.4.
- Self-administered chemotherapy drugs are covered under section 4.12.7 unless the benefits under this Prescription Drug Benefit allow for lower out of pocket costs to you.
- Injectable medications received in your Provider’s office are covered under section 4.3.3.
• Infusions, including infused medications, received at Outpatient Facilities are covered under section 4.7.1.
• Some prescription drugs require Prior Authorization or an exception to the formulary in order to be covered; these may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in our Prescription Drug Formulary available on our website at [ProvidenceHealthPlan.com](http://ProvidenceHealthPlan.com) or by contacting Customer Service.

**4.14.2 Use of Out-of-Network Pharmacies**

On rare occasions, such as urgent or emergency situations, you may need to use an Out-of-Network 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 Providence Health Plan a Prescription Drug Reimbursement form. This form is available on our website or by contacting Customer Service. When you submit the completed Prescription Drug Reimbursement form, include any itemized pharmacy receipts along with an explanation as to why you used an Out-of-Network 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 Network Pharmacy contracted rates, less your Deductible, Copayment or Coinsurance if applicable. You are responsible for any amounts above our contracted rates.

**4.14.3 Prescription Drug Formulary**

**Generic and Brand-Name prescription Drugs**

The Providence Health Plan Formulary is a list of Food and Drug Administration (FDA)-approved prescription generic, brand and specialty drugs. It is designed to offer drug treatment choices for covered medical conditions. Formulary status is given to drugs which meet evidence-based assessment of therapeutic effectiveness, safety, pharmacoeconomic value and offer an important advantage to existing Formulary alternatives.

The Formulary can help you and your Qualified Practitioner choose effective medication that is less costly and minimize your out-of-pocket expense. There are effective generic drug choices that treat most medical conditions.

Not all FDA approved drugs are covered by Providence Health Plan. Non-formulary drug requests require a formulary exception, must be FDA-approved, Medically Necessary, and require by law a prescription to dispense. See section 6.1 under [Claims Involving Prior Authorization and Formulary Exception](#).

Newly approved FDA drugs will be reviewed by the Oregon Region Pharmacy and Therapeutics Committee for safety and Medical Necessity within 12 months after the drug becomes available on the market. In the case of an urgent situation, we will authorize the use of a newly approved FDA drug during our review period so a Member does not go without Medically Necessary treatment.

To access the formulary for your plan, visit [https://healthplans.providence.org/members/pharmacy-resources/](https://healthplans.providence.org/members/pharmacy-resources/).

**4.14.4 Prescription Drugs**

**Generic and Brand-Name prescription Drugs**

Both generic and brand-name drugs are covered benefits subject to the terms of your Benefit Summary. In general, generic drugs are subject to lower Copayments or Coinsurances than brand-name drugs. Please refer to your Benefit Summary for your Copayment or Coinsurance information.
If your brand-name benefit includes a Copayment, or a Coinsurance, regardless of the reason or Medical Necessity, and you request a brand-name drug, or if your provider prescribes a brand-name drug when a generic is available, you will be responsible for the difference in cost between the brand-name and generic drug, in addition to the brand-name drug Copayment or Coinsurance indicated on the Benefit Summary. Your total cost, however, will never exceed the actual cost of the drug. The difference in cost between the brand-name and generic drug will not be applied toward your Out-of-Pocket Maximum, and you will continue to be responsible for the difference in cost after your Out-of-Pocket Maximum is met.

**Affordable Care Act Preventive Drugs**

Affordable Care Act (ACA) preventive drugs are medications, including contraceptives, which are listed in our formulary and are covered at no cost when received from participating pharmacies as required by the ACA. Over-the-counter preventive drugs received from participating Pharmacies will not be covered in full under the ACA preventive benefit without a written prescription from your Qualified Practitioner.

### 4.14.5 Prescription Drug Quantity

Prescription dispensing limits, including refills, are as follows:

1. topicals, up to 60 grams;
2. liquids, up to eight ounces;
3. tablets or capsules, up to 100 dosage units;
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; and
5. FDA approved women’s prescription contraceptives: up to 3-months initial dispensing, then up to 12-months subsequent dispensing at any Network Pharmacy.

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.

### 4.14.6 Network Mail-Order and Preferred Retail Pharmacies

Up to a 90-day supply of 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 Network mail-order or preferred retail Pharmacy will be covered subject to the following specific provisions:

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

When using a mail-order pharmacy, payment is required prior to processing your order. If there is a negative change in our Network mail-service or preferred retail Pharmacies, you will be notified of the change at least 30 days in advance.

### 4.14.7 Prescription Drug Limitations

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 after the drug becomes available on the market for Formulary consideration.
2. Certain drugs require Prior Authorization for Medical Necessity, place of therapy, length of therapy, step therapy, number of doses or dispensing limits. Step therapy uses our pharmacy claims history to confirm if certain drugs have been tried first by a Member. If a drug has not been tried first, cannot be tried first, or if the drug history is not available, Prior Authorization is required. For some drugs, we limit the amount of the drug we will cover. You or your Qualified Practitioner can contact us directly to request Prior Authorization. If you have questions regarding a specific drug, please call Customer Service.

3. Specialty drugs are injectable, infused, oral, topical, 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, specialty drugs are limited to a 30-day supply. Specialty drugs are indicated on our Formulary. In rare circumstances specialty medications may be filled for greater than a 30-day supply; in these cases, additional specialty cost share(s) may apply.

4. Self-injectable medications are covered when they are being self-administered and labeled by the FDA for self-administration; in some cases, a prior authorization may be required for the drug. Documentation of self-administration may also be required. Drugs labeled for self-administration that are being administered by a provider will fall to the Member’s medical benefit.

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

6. Compound prescription drugs must contain at least one ingredient that is an FDA-approved prescription drug in a therapeutic amount, must meet our medical necessity criteria and must be purchased at a Network Pharmacy. Compounded drugs from bulk powders that are not a component of an FDA approved drug are not covered. Claims are subject to clinical review for Medical Necessity and are not guaranteed for payment.

7. In accordance with the ACA, your Plan provides coverage in full of certain medications, including contraceptives, when these medications are purchased from Network Pharmacies. Not all preventive medications are required to be covered in full by the ACA. Medications in this category may be subject to medical management techniques to determine frequency, method, treatment, or setting. Brand medications for which a generic is available will not be covered in full unless the Member has received Prior Authorization from Providence Health Plan.

4.14.8 Prescription Drug Exclusions

In addition to the Exclusion listed in section 5, Prescription Drug Exclusions are as follows:

1. Drugs or medications delivered, injected or administered to you by a physician or other provider or another trained person (see section 4.3.5);
2. Amphetamines and amphetamine derivatives, except when used in the treatment of narcolepsy or hyperactivity in children and adults;
3. Drugs or medications prescribed that do not relate to the treatment of a covered illness or injury;
4. Drugs used for the treatment of fertility/infertility;
5. Fluoride, for Members over 16 years of age;
6. Drugs that are not provided in accordance with our Formulary management program or are not provided according to our medical policy;
7. Drugs used in the treatment of fungal nail conditions;
8. Over-the-counter (OTC) drugs, medications or vitamins, that may be purchased without a provider’s written prescription, except as required by federal or Oregon state law;
9. Prescription drugs, including prescription combination drugs, that contain OTC products or are available in an OTC therapeutically similar form;
10. Drugs dispensed from pharmacies outside the United States, except when prescribed for Urgent Care and Emergency Medical Conditions, except as required by federal or Oregon state law;
11. Drugs on a prescription-only status as required by state or local law;
12. Replacement of lost or stolen medication;
13. Drugs or medicines used to treat sexual dysfunction (this exclusion does not apply to Mental Health Covered Services);
14. Drugs used in the treatment of drug-induced fatigue, general fatigue and idiopathic hypersomnia;
15. Drugs dispensed or compounded by a pharmacist that do not have at least one FDA-approved medication in therapeutic amount;
16. Drugs used for weight loss of for cosmetic purposes;
17. Drug kits, unless the product is available solely as a kit. Kits typically contain a pre-packaged drug along with items associated with the administration of the drug (e.g., gloves, shampoo);
18. Prenatal vitamins that contain docosahexaenoic acid (DHA);
19. Drugs that are not FDA-approved or are designated as “less than effective” by the FDA (also known as a “DESI” drug); and
20. Vaccines, immunizations and preventive medications solely for the purpose of travel, school or work.

4.14.9 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 Contract.

4.15 PEDIATRIC VISION SERVICES
This Contract provides coverage for routine Pediatric Vision Services for Members under age 19. Coverage is provided as shown in your Benefit Summary. Pediatric Vision Services end on the last day of the month of the Member’s 19th birthday.

**Pediatric vision exclusions:**
- Two pairs of glasses instead of bifocals;
- Replacement of lenses, frames or contacts;
- Medical or surgical treatment;
- Orthoptics, vision training or supplemental testing;
- Contact lens insurance policies and service agreements;
- Artistically painted or non-prescription contact lenses;
- Additional office visits for contact lens pathology; and
- Contact lens modification, polishing or cleaning.

4.16 ADULT VISION SERVICES
The Plan provides coverage for routine Adult Vision Services for Members age 19 and over. Coverage is provided as shown in your Benefit Summary.

**Adult vision exclusions:**
- Two pairs of glasses instead of bifocals;
- Replacement of lenses, frames or contacts;
- Medical or surgical treatment;
- Orthoptics, vision training or supplemental testing;
- Contact lens insurance policies and service agreements;
- Artistically painted or non-prescription contact lenses;
• Additional office visits for contact lens pathology; and
• Contact lens modification, polishing or cleaning.

4.17 PEDIATRIC DENTAL BENEFIT

The Pediatric Dental Benefit provides coverage for routine Dental Services for Members under age 19. See your Pediatric Dental Benefit Summary for a description of your Pediatric Dental Benefit, Covered Services and Limitations. The Pediatric Dental Benefit ends on the last day of the month of the Member’s 19th birthday.

Pediatric Dental Limitations

Class I. Diagnostic and Preventive Services:

• Two evaluations (D0120, D0140, D0145, D0150, D0160, D0170) per 12 months, including a maximum of one comprehensive evaluation. D0150 is covered twice per 12 months when performed by different providers, D0150 is limited to once per 12 months when performed by the same provider, and D0180 is limited to once per 12 months;
• Two prophylaxis (D1110 or D1120) per 12 months;
• Two fluoride treatments are covered every 12 months;
• Bitewing x-rays, one set per 12 months;
• Periapical x-rays, limited to six films per 12 months for Members under age six (not on the same date of service as a panoramic radiograph);
• One full mouth x-ray or panoramic film (starting at age six) per 60 months; maximum of one set of x-rays per office visit;
• One space maintainer (D1510, D1515, D1520, D1525, D1550, D1555 or D1575) per 24 months per arch to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment) (no reimbursement for the replacement of lost or damaged removable space maintainers);
• One sealant per tooth per 36 months, (limited to occlusal surfaces of posterior permanent teeth without restorations or decay) for Members under age 16;
• Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service); and
• Two pre-diagnostic assessments of patient (D0191) per 12 months.

Class II. Basic Services:

• Amalgam and composite fillings excluding posterior composite fillings (restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 36 months;
• Pin retention of fillings (multiple pins on the same tooth are allowable as one pin); and
• General anesthesia and analgesic (only when provided in connection with a covered periodontal and oral surgery procedure(s) when determined to be medically or dentally necessary for documented handicapped or uncontrollable Members or justifiable medical or dental conditions).

Class III. Major Services:

• Oral surgery, including postoperative care for:
  o Removal of teeth, including impacted teeth.
  o Extraction of tooth root;
  o Cornonecstomy, intentional partial tooth removal, limited to one per lifetime;
  o Alveoleectomy and alveoplasty (alveoplasty is not covered when provided in conjunction with tooth extraction);
  o Frenulectomy limited to once per lifetime per arch for Members age 12 through 18;
  o Excision of periocoronal gingiva, exostosis, or hyper plastic tissue;
  o Excision of oral tissue for biopsy;
  o Reimplantation of a natural tooth; and
Excision of a tumor or cyst and incision and drainage of an abscess or cyst.
- **Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:**
  - Root canal therapy; once per lifetime, per permanent tooth (not covered for third molars);
  - Retreatment of previous root canal therapy, on anterior teeth, one per lifetime, not within 24 months when done by same dentist or dental office;
  - Pulpotomy;
  - Apicoectomy, on anterior teeth only; and
  - Retrograde fillings, per root per lifetime.

- **Periodontic services, limited to:**
  - Two periodontal cleanings, in addition to adult Prophylaxis, per p12 month period;
  - One root scaling and planing, once per 24 months per quadrant;
  - Scaling in presence of generalized moderate or severe gingival inflammation, full mouth, after oral evaluation in lieu of a covered D1120/D1110, limited to once per two years;
  - Gingivectomy once per 36 months per quadrant; and
  - One full mouth debridement per 12 month period.

- **Restoration services, limited to:**
  - Cast metal, stainless steel, porcelain/ceramic crowns for teeth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling one per 7 years from the original date of placement (permanent and porcelain fused to metal crowns limited to Members age 16 through 18);
  - Recementing and repair of crowns, dentures and bridges;
  - Sedative filling;
  - Post removal; and
  - Crown build-up for non-vital teeth.

- **Prosthetic services (for Members ag 16 through 18), limited to:**
  - Removable resin base partial dentures and full dentures (complete or immediate);
  - Replacement of dentures that cannot be repaired after ten years for full dentures and after five years for partial dentures from the date of last placement;
  - One relining or rebasing of existing removable dentures per 36 months (only after six months from date of last placement, unless an immediate prosthesis replacing at least three teeth;
  - Addition of teeth to existing partial denture; and
  - Construction of bridges, replacement limited to once per 60 months.

**Pediatric Dental Exclusions**
- Oral surgery requiring the setting of fractures or dislocations;
- Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development of malformations where such services should not be performed in a dental office;
- Dispensing of drugs;
- Hospitalization for any dental procedure;
- Replacement due to loss or theft of prosthetic appliance;
- Services to treat temporomandibular joint syndrome;
- Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth. The prophylactic removal of these teeth for Medically Necessary orthodontia services may be covered subject to review;
- Replacement of dentures, inlays, onlays or crowns that can be repaired to normal function;
- Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions except if the developmental malformation and or congenital conditions cause severe, dysfunctional handicapping malocclusion that requires Medically Necessary orthodontia services;
- Experimental/Investigational procedures;
- Treatment of cleft palate, malignancies or neoplasms (see your medical benefits and section 4.12.6 for coverage of these conditions); and
• Orthodontics (see your medical benefits and section 4.12.6 for coverage of Medically Necessary orthodontics to treat craniofacial anomalies.
5. EXCLUSIONS

In addition to those Services listed as not covered in section 4, the following are specifically excluded from coverage under this Contract.

**General Exclusions:**

**We do not cover Services and supplies which:**

- Are not provided;
- Are provided without charge or for which you would not be required to pay if you did not have this coverage;
- Are received before the Effective Date of Coverage;
- Are not a Covered Service or relate to complications resulting from a Non-Covered Service, except for Services provided as Emergency Care as described in section 4.5;
- Are not furnished by a Qualified Practitioner or Qualified Treatment Facility;
- Are provided by or payable under any health benefit plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law;
- Are provided while you are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies, except to the extent provided by 38 U. S. C. § 1729 as it relates to non-military Services provided at a Veterans Administration Hospital or facility;
- Are provided while you are in the custody of any law enforcement authorities or while incarcerated, except as provided in section 3.3;
- Are self-administered (except as provided in 4.12.7), are prescribed by you for your own benefit, or are provided or prescribed by a person who resides in your home or is a member of your family. “Member of your family” for this purpose means any person who could possibly inherit from you under the intestate succession law of any state, plus any in-law, step relative, foster parent, or domestic partner of you or of any such person;
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos and books, educational programs to which drivers are referred by the judicial system and volunteer mutual support groups;
- Are provided to yield primarily educational outcomes. An outcome is “primarily educational” if the outcome’s fundamental, first, or principal character is to provide you with enduring knowledge, skill, or competence through a process of repetitive positive reinforcement over an extended length of time. An outcome is “enduring” if long-lasting or permanent;
- Are performed in association with a Service that is not covered under this Contract;
- Are provided for any injury or illness that is sustained by any Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers’ Compensation Act or similar law is required for the Member. This exclusion also applies to injuries and illnesses that are the subject of a disputed claim settlement or claim disposition agreement under a Workers’ Compensation Act or similar law. This exclusion does not apply to Members who are exempt under any Workers’ Compensation Act or similar law;
- Are payable under any automobile medical, personal injury protection (“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 and whether or not you are refused payment for failure to satisfy an term of such coverage. If such coverage is required by law and you unlawfully fail to obtain it, benefits will be deemed to have been payable to the extent of that requirement. This exclusion also applies to charges applied to the deductible of such contract or insurance. Any benefits or Services provided under this Contract that are subject to this exclusion are provided solely to assist you and such assistance does not waive our right to reimbursement or subrogation as specified in section 6.3. This exclusion also applies to Services and supplies after you have received proceeds from a settlement as specified in section 6.3.3;
• Are provided in an institution that specializes in treatment of developmental disabilities, except as provided in section 4.10.2;
• Are provided for treatment or testing required by a third party or court of law which is not Medically Necessary;
• Are Experimental/Investigational;
• Are determined by us not to be Medically Necessary for diagnosis and treatment of an injury or illness;
• Are received by a qualified Member under the Oregon Death with Dignity Act;
• Have not been Prior Authorized as required by this Contract;
• Relate to any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member if such Member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, “illegal” means any engagement or act that would constitute a felony or misdemeanor punishable by up to a year’s imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or medical condition (i.e., a physical or mental health condition); and
• Relate to a civil revolution or riot, duty as a Member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.

We do not cover:
• Charges that are in excess of the Usual, Customary and Reasonable (UCR) cost;
• Custodial Care;
• Transplants, except as described in the Benefit Summary and section 4.13;
• Services for Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, Durable Medical Equipment (DME) and Hearing Aids, except as described in section 4.9;
• 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, rehabilitative and habilitative Services, except as provided in sections 4.6.3, 4.6.4, 4.7.2 and 4.7.3;
• “Telephone visits” by a physician or “environment intervention” or “consultation” by telephone for which a charge is made to the patient, except as provided in section 4.3.2;
• “Get acquainted” visits without physical assessment or diagnostic or therapeutic intervention provided (except as provided in 4.1.2) and treatment sessions by computer Internet service;
• Missed appointments;
• Non-emergency medical transportation;
• Allergy shots and allergy serums, except as provided in section 4.3.5;
• All Services and supplies related to the treatment of obesity or morbid obesity, except as provided in section 4.1;
• Services for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas, except as provided in section 4.1;
• Transportation or travel time, food, lodging accommodations and communication expenses except as provided in sections 3.7 and 4.13 and with our prior approval;
• Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
• Massage therapy;
• Biofeedback, except as provided in section 4.12.8;
• Thermography;
• Homeopathic procedures;
• Comprehensive digestive stool analysis, cytotoxic food allergy test, dark-field 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, and zinc tolerance test;
• Chiropractic manipulation and acupuncture, except as provided in section 4.12.11 and 4.12.12;
• Light therapy for seasonal affective disorder, including equipment;
• Any vitamins, dietary supplements, and other non-prescription supplements, except as required by federal or Oregon state law;
• Services for genetic testing are excluded, except as provided in Section 4.12.1. 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 as provided in section 4.18 or when provided as Extra Values or Discounts (see our website at ProvidenceHealthPlan.com), where available;
• Services for Genetic Services including supplies and drugs, except as approved by us and described in section 4;
• Services, including routine physical examination, immunizations and vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel;
• Non-sterile examination gloves;
• Sales taxes, handling fees and similar surcharges, as explained in the definition of UCR; and
• Air ambulance transportation for non-emergency situations unless approved by us in advance.
• Conditions for mental and nervous conditions not specified as excluded in section 12 Definitions, for Mental Health and Chemical Dependency;
• Services provided under a court order or as a condition of parole or probation or instead of incarceration which are not Medically Necessary;
• Personal growth services such as assertiveness training or consciousness raising;
• School counseling and support services, peer support services, tutor and mentor services; independent living services, household management training, and wraparound services that are provided by a school or halfway house and received as part of an education or training program;
• Recreation services, therapeutic foster care, wraparound Services; emergency aid to household items and expenses; services to improve economic stability, and interpretation services;
• Evaluation or treatment for educations, professional training, employment investigations, and fitness for duty evaluations;
• Community care facilities that provide 24 hour non-medical residential care;
• Speech therapy, physical therapy and occupational therapy services provided in connection with treatment of psychosocial speech delay, learning disorders, including intellectual disability and motor skill disorders, and educational speech delay including delayed language development (except as provided in sections 4.6.3, 4.6.4, 4.7.2 and 4.7.3);
• Counseling related to family, marriage, sex and career including, but not limited to, counseling for adoption, custody, family planning or pregnancy, in the absence of a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis;
• Neurological Services and tests including, but not limited to EEGs; PET, CT, MRA and MRI imaging Services; and beam scans (except as provided in section 4.6.1);
• Vocational, pastoral or spiritual counseling; and
• Dance, poetry, music or art therapy, except as part of an approved treatment program.
Exclusions that apply to Provider Services:
- Services of homeopaths; faith healers; or lay, unlicensed direct entry, and certified professional midwives; and
- Services of any unlicensed providers.

Exclusions that apply to Reproductive Services:
- All services related to sexual disorders or dysfunctions regardless of gender or cause. This exclusion does not apply to Mental Health Covered Services;
- All services for the treatment of infertility, including all services related to surrogate parenting. For the purpose of this exclusion, infertility is defined as the inability to become pregnant after a year of unprotected intercourse or the inability to carry a pregnancy to term as evidenced by three consecutive spontaneous abortions;
- Termination of pregnancy, unless there is a severe threat to the mother, or if the life of the fetus cannot be sustained;
- Reversal of voluntary sterilization;
- Condoms and other over-the-counter birth control products; and
- Services provided in a premenstrual syndrome clinic or holistic medicine clinic.

Exclusions that apply to Vision Services:
- Surgical procedures which alter the refractive character of the eye, including, but not limited to laser eye surgery, radial keratotomy, myopic keratomelelisis and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia, hyperopia or astigmatism;
- Services for routine eye care and vision care, vision exams/screenings, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in sections 4.1.1, 4.1.5, 4.5.3, 4.9.2, and 4.15, and 4.16; and
- Orthoptics and vision training.

Exclusions that apply to Hearing Services:
- Hearing aids, hearing therapies and/or devices, including all services related to the examination and fitting of the hearing aids, except as provided in section 4.9.5.

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, and dental implants), except as stated in sections 4.12.6;
- Services for orthognathic surgery, except as approved by us and described in section 4.12.6;
- Services to treat temporomandibular joint syndrome (TMJ);
- Dentures and orthodontia; except as provided in sections 4.12.6; and
- Services for routine dental care, dental exams/screenings, and repair, except as provided in section 4.17.

Exclusions that apply to Foot Care Services:
- Routine foot care, such as removal of corns and calluses, except for Members with diabetes; and
- Services for insoles, arch supports, heel wedges, lifts and orthopedic shoes, except as described in section 4.9.2.

Exclusions that apply to Prescription Drugs, Medicines and Devices:
- Outpatient prescription drugs, medicines and devices except as provided in sections 4.2.4, 4.12.7 and 4.14; and
- Any drug, medicine, or device that does not have the United States Federal Drug Administration formal market approval through a New Drug Application, Pre-market Approval, or 510K.
6. CLAIMS ADMINISTRATION

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

6.1 CLAIMS PAYMENT

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

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

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

Claims Involving Prior Authorization and Formulary Exception (Pre-Service Claims)
- For services that do not involve urgent medical conditions: Providence Health Plan will notify your provider or you of its decision within two business days after the Prior Authorization request is received. If additional information is needed to process the request, Providence Health Plan will notify the provider and the provider will have 45 days to submit the additional information. Within two days of receipt of the additional information, Providence Health Plan will complete its review and notify your provider or you of its decision. If the information is not received within 45 days, the request will be denied.
- For services that involve urgent medical conditions: Providence Health Plan will notify your provider or you of its decision within 72 hours after the Prior Authorization request is received. If Providence Health Plan needs additional information to complete its review, it will notify the requesting provider or you within 24 hours after the request is received. The requesting provider or you will then have 48 hours to submit the additional information. Providence Health Plan will complete its review and notify the requesting provider or you of its decision by the earlier of (a) 48 hours after the additional information is received or, (b) if no additional information is provided, 48 hours after the additional information was due.
- For services that involve formulary exceptions: For standard requests, Providence Health Plan will notify your provider or you of its decision within 72 hours after receipt of the request. For expedited requests, Providence Health Plan will notify your provider or you of its decision within 24 hours after receipt of the request. To qualify for expedited review, the request must be based upon exigent circumstances.
Claims Involving Concurrent Care Decisions
If an ongoing course of treatment for you has been approved by Providence Health Plan and it then determines through its medical cost management procedures to reduce or terminate that course of treatment, you will be provided with advance notice of that decision. You may request a reconsideration of that decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. Providence Health Plan will then notify you of its reconsideration decision within 24 hours after your request is received.

6.1.1 Timely Submission of Claims
We will make no payments for claims received more than 365 days after the date of Service. Exceptions will be made if we receive documentation of your legal incapacitation. Payment of claims submitted by the Oregon state Medicaid agency or a prepaid managed care health services organization described in ORS 414.651 (i.e., a Coordinated Care Organization) will be made in accordance with ORS 743.847, which establishes payment requirements for claims submitted by the Oregon state Medicaid agency.

Payment of all claims will be made within the time limits required by OAR 836-080-0235, the Oregon Division of Financial Regulation’s administrative rule setting standards for prompt payment. Please send all claims to:

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

Mental Health and Chemical Dependency claims:
PBH
P.O. Box 30602
Salt Lake City, UT 84130

Routine Vision claims:
Vision Service Plan
Attention: Claims Services
P.O. Box 385018
Birmingham, AL 35238-5018

Pediatric Dental Benefit claims:
Dental Processing Center, Inc.
P.O. Box 1126
Elk Grove Village, IL 60009

6.1.2 Right of Recovery
We have the right, upon demand, to recover from a recipient the value of any benefit or claim payment that exceeded the benefits available under this Contract. Our right of recovery applies to any excess benefit, including, but not limited to, benefits obtained through fraud, error, or duplicate coverage relating to any Member. If timely repayment is not made, we have the right, in addition to any other lawful means of recovery, to deduct the value of the excess benefit from any future benefit that otherwise would have been available to the affected Member(s) from us under any contract.
6.2 COORDINATION OF BENEFITS

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

6.2.1 Definitions Relating to Coordination of Benefits

**Plan**

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

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

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

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

**This Plan**

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

The order of benefit determination rules listed in section 6.2.2 determine whether This Plan is a Primary plan or Secondary plan when a Member has health care coverage under more than one Plan.

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

**Allowable expense**

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

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
2. If the Member is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If the Member is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If the Member is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan’s payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan’s payment arrangement and if the provider’s contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
5. The amount of any benefit reduction by the Primary plan because the Member has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

**Custodial parent**
A Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the Dependent child resides more than one half of the Calendar Year excluding any temporary visitation.

**6.2.2 Order of Benefit Determination Rules**
When a Member is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan.
   1. Except as provided in Paragraph (2) below, a Plan that does not contain a COB provision that is consistent with the State of Oregon’s COB regulations is always primary unless the provisions of both Plans state that the complying Plan is primary.
   2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

B. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
C. Each Plan determines its order of benefits using the first of the following rules that apply:

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

2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Member is a Dependent child covered by more than one Plan the order of benefits is determined as follows:
   a) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
      i. The Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary plan; or
      ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
   b) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
      i. If a court decree states that one of the parents is responsible for the Dependent child’s health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
      ii. If a court decree states that both parents are responsible for the Dependent child’s health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
      iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
      iv. If there is no court decree allocating responsibility for the Dependent child’s health care expenses or health care coverage, the order of benefits for the Dependent child are as follows:
         • The Plan covering the Custodial parent, first;
         • The Plan covering the spouse of the Custodial parent, second;
         • The Plan covering the non-custodial parent, third; and then
         • The Plan covering the Dependent spouse of the non-custodial parent, last.
   c) For a Dependent child covered under more than one Plan of individuals who are not the parents of the Dependent child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the Dependent child.
   d) For a Dependent child:
      i. Who has coverage under either or both parents’ plans and also has coverage as a Dependent under a spouse’s plan, the rule in paragraph (5) applies.
      ii. In the event the Dependent child’s coverage under the spouse’s plan began on the same date as the Dependent child’s coverage under either or both parents’ plans, the order of benefits shall be determined by applying the birthday rule in Subparagraph (a) to the Dependent child’s parent(s) and the Dependent’s spouse.

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

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

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

6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than we would have paid had we been the Primary plan.

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

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

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

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

6.2.6 Right of Recovery
If the amount of the payments made by us is more than we should have paid under this COB section, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services
6.2.7 Medicare Non-Duplication of Coverage

If you are entitled to Medicare benefits and are covered under this Contract at the same time, Medicare is primary and we are secondary.

- If the total reimbursement from Medicare, including amounts applied toward any deductible, is less than, equals or exceeds the benefits payable under this Contract, then no additional payment will be made by us.
- If you are entitled to Medicare Part A, we assume you have enrolled in Medicare Part B and we will not provide benefits for any part of a Service that would have been paid for under Medicare Part B had you enrolled.

6.3 THIRD-PARTY LIABILITY/SUBROGATION

The following provisions will apply when you or any other Member has received Services for a condition for which one or more third parties may be responsible. “Third party” means any person other than the Member (the first party to the provisions of this Contract), and Providence Health Plan (the second party), and includes any insurance carrier providing liability or other coverage potentially available to the Member. For example, uninsured or underinsured motorist coverage, no-fault medical payments (auto, homeowners or otherwise), or other individual or group insurance (including student plans) whether under the Member’s policy or not, are subject to recovery by us as a third-party recovery. Failure by the Member to comply with the terms of this section will be a basis for us to deny any claims for benefits arising from the condition or to terminate the Member’s coverage under this Contract as specified in section 9.4. In addition, you or the Member must execute and deliver to us and to other parties any document requested by us which may be appropriate to confirm or secure the rights and obligations of the Member and Providence Health Plan under these provisions.

6.3.1 Third-Party Liability/Subrogation and How it Affects you

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

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

“Subrogation” means that we may collect directly from the third party to the extent we have paid for third-party liabilities. Because we have paid for the Member’s injuries, we, rather than the Member, are entitled to recover those expenses. Prior to accepting any settlement of the Member’s claim against a third party, the Member must notify us in writing of any terms or conditions offered in settlement and must notify the third party of our interest in the settlement established by this provision.

To the maximum extent permitted by law, we are subrogated to the Member’s rights against any third party who is responsible for the condition, have the right to sue any such third party in the Member’s name, and have a security interest in and lien upon any recovery to the extent of the
amount of benefits paid by us and for our expenses in obtaining a recovery. If the Member should either decline to pursue a claim against a third party that we believe is warranted or refuse to cooperate with us in any third party claim that the Member does pursue, we have the right to pursue such claim directly, including commencing a legal action against such third party or intervening in any action that the Member may have commenced.

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

6.3.2 Proceeds of Settlement or Recovery

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

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

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

6.3.3 Suspension of Benefits and Reimbursement

After the Member has received proceeds of a settlement or recovery from the third party, the Member is responsible for payment of all medical expenses for the continuing treatment of the illness or injury that Providence Health Plan would otherwise be required to pay under this Contract until all proceeds from the settlement or recovery have been exhausted. If the Member has failed to reimburse us as required by this section, we are entitled to offset future benefits otherwise payable under this Contract, or under any future contract or plan with us, to the extent of the value of the benefits advanced under this section.
If the Member continues to receive medical treatment for the condition after obtaining a settlement or recovery from one or more third parties, we are not required to provide coverage for continuing treatment until the Member proves to our satisfaction that the total cost of the treatment is more than the amount received in settlement or recovered from the third party, after deducting the cost of obtaining the settlement or recovery. We will only cover the amount by which the total cost of benefits that would otherwise be covered under this Contract, calculated using our UCR charges for such Services, exceeds the amount received in settlement or recovery from the third party. We are entitled to suspend such benefits even if the total amount of such settlement or recovery does not fully compensate the Member for other damages, particularly including lost wages or pain and suffering.

Any settlement arising out of an injury or illness covered under this Contract will be deemed first to compensate the Member for the Member’s medical expenses, regardless of any allocation of proceeds in any settlement document that we have not approved in advance. In no event shall the amount reimbursed to Providence Health Plan be less than the maximum permitted by law.
7. PROBLEM RESOLUTION

7.1 INFORMAL PROBLEM RESOLUTION

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

7.2 MEMBER GRIEVANCE AND APPEAL

Definitions:

Adverse Benefit Determination
An Adverse Benefit Determination means a:

- Denial of eligibility for or termination of enrollment in this Plan;
- Rescission or cancellation of coverage under this Plan;
- Imposition of a pre-existing condition exclusion, source-of injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise Covered Services;
- Determination that a health care item or service is Experimental/Investigational or not Medically Necessary; or
- Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care.

Appeal
A type of Grievance that is a written request from a Member or an Authorized Representative of the Member requesting further consideration of an Adverse Benefit Determination.

Authorized Representative
An individual who by law or by the consent of a Member may act on behalf of the Member.

Concurrent Care
An approved ongoing course of treatment to be provided over a period of time or for a specified number of treatments.

Grievance
A request submitted by a Member or an Authorized Representative of a Member:

- In writing, for an internal Appeal or an external review; or in writing or orally, for an expedited response or an expedited external review; or
- A written complaint submitted by a Member or an Authorized Representative of a Member regarding the:
  - Availability, delivery or quality of a health care service;
  - Claims payment, handling or reimbursement for health care services and, unless the Member has not submitted a request for an internal Appeal, the complaint is not disputing an Adverse Benefit Determination; or
  - Matters pertaining to the contractual relationship between a Member and Providence Health Plan.
7.2.1 Your Appeal and Grievance Rights
If you disagree with our decision about your medical bills or health care coverage you have the right
to an internal review. You may request a review if you have received an Adverse Benefit
Determination. You may also file a quality of care or general complaint or Grievance with us. You
may appoint an Authorized Representative to act on your behalf during your Grievance or Appeal.
Please include as much information as possible including the date of the incident, the names of
individuals involved, and the specific circumstances. In filing a Grievance or Appeal:
• You can submit written comments, documents, records and other information relating to
  your Grievance or Appeal and we will consider that information in our review process.
• You can, upon request and free of charge, have reasonable access to and copies of the
documents, records, and other information relevant to our decision, including the specific
internal rule, guidance, protocol, or other similar criterion relied upon to make an Adverse
Benefit Determination.
• You can be represented by anyone of your choice at all levels of Appeal.

Filing a Grievance or Appeal does not affect your right to receive benefits for Covered Services as
otherwise provided under this Plan.

If you received the services that were denied in our Adverse Benefit Determination, and if the
Adverse Benefit Determination is upheld by internal or external review, you will be financially
responsible for any benefits paid by the Plan for such services pursuant to Oregon state law.

To the extent possible, Customer Services will resolve complaints filed by telephone at the point of
Service. We will acknowledge all non-urgent pre-service and post-service Grievances and Appeals
within seven days of receipt and resolve within 30 days or sooner depending on the clinical urgency.
Urgent medical conditions and concurrent care have different resolution timelines as noted below.

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

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

7.2.2 Grievance or Appeal
You must file your internal Grievance or Appeal within 180 days of the date on our notice of the
initial Adverse Benefit Determination, or that initial Determination will become final. Please advise
us of any additional information that you want considered in the review process. If you are seeing an
Out-of-Network Provider, you should contact the provider’s office and arrange for the necessary
records to be forwarded to Providence Health Plan for the review process. Your Grievance or Appeal
will be reviewed by Providence Health Plan staff not involved in the initial determination. You may
present your case in writing. Once a final determination is made, you will be sent a written
explanation of the decision.
7.2.3 External Review

If you are not satisfied with the internal Grievance or Appeal decision and your Appeal involves (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, or (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care, you have the right to an external review by an Independent Review Organization (IRO). Your request must be made in writing within 180 days of receipt of the internal Grievance or Appeal decision, or that internal decision will become final. If you agree, we may waive the requirement that you exhaust the internal review process before beginning the External Review process. We will notify the Oregon Division of Financial Regulation within two business days of receiving your request for external review, at which point an IRO will be assigned to the case by the Oregon Division of Financial Regulation and we will forward complete documentation regarding the case to the IRO.

If you request an external review you must agree to authorize release of medical records needed by the IRO and submit any additional information to the IRO no later than five days after the appointment of the IRO, or 24 hours in cases of expedited review. The IRO is entirely independent of Providence Health Plan and performs its review under a contract with the Oregon Insurance Division. The IRO will notify you and us of its decision within three days for expedited reviews and within 30 days when not expedited. We agree to be bound by and to comply with the IRO decision when the decision involves, (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, or (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care.

We pay for all costs for the handling of external review cases and we administer these provisions in accordance with the insurance laws and regulations of the state of Oregon. If we do not comply with the IRO decision, we may be penalized by the Oregon Division of Financial Regulation, and you have the right to sue us under applicable Oregon law.

7.2.4 Information Available Upon Request

We will provide, upon request, annual summaries of Grievances and Appeals, utilization review policies, quality assessment activities, our health promotion and disease prevention activities, our scope of network and accessibility of services; and the results of all publicly available accreditation surveys.

7.2.5 How to Submit Grievances or Appeals and Request Appeal Documents

You may contact Customer Service at 503-574-7500 or 800-878-4445. If you are hearing impaired and use a Teletype (TTY) Device, please call our TTY line at 711. Written Grievances or Appeals should be sent to:

Providence Health Plan
Appeals and Grievance Department
P.O. Box 4158
Portland, OR 97208-4158

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

Providence Health Plan
3601 SW Murray Blvd., Ste. 10
Beaverton, OR 97005
7.2.6 Assistance with your Grievance or Appeal

You may, at any time during the Appeal and Grievance process, seek assistance from the Oregon Division of Financial Regulation with your concerns regarding our decisions and benefits. You may contact the Oregon Division of Financial Regulation at:

Oregon Division of Financial Regulation
Consumer Protection Unit
P.O. Box 14480
Salem, OR 97309-0405

503-947-7984 (phone)
888-877-4894 (toll-free)
503-378-4351 (fax)

cp.ins@state.or.us (email)
http://www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx (website)
8. ELIGIBILITY, ENROLLMENT, PREMIUMS AND TERMINATION

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

8.1 POLICYHOLDER ELIGIBILITY AND ENROLLMENT

8.1.1 Eligibility Requirements

An individual is eligible for coverage as a Policyholder when:

1. The individual has applied for coverage by completing our Individual Application; and
2. The individual resides in our Oregon Service Area as stated in section 13; and
3. The individual has been approved by us for enrollment.

8.1.2 Open Enrollment and Effective Date of Coverage

This Plan has an annual Open Enrollment period.

To request coverage, an Eligible Individual must apply with Providence Health Plan during Open Enrollment. The Open Enrollment period is November 1st through December 15th, with coverage effective January 1st of the following Calendar Year.

To be eligible for an offer of coverage, your application must be submitted by the last day of the Open Enrollment period.

In order for coverage to become effective, we must receive your initial month’s premium in full by the first day of the Plan Year, January 1st.

If your initial month’s premium is not received by January 1st, your application and our offer of coverage are void.

For enrollment outside of Open Enrollment, see section 8.4 Special Enrollment.

8.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

8.2.1 Eligibility Requirements

Each Dependent is eligible for coverage as an Eligible Family Dependent when:

1. The Dependent has applied for coverage by completing our Individual Application; and
2. The Dependent resides in our Oregon Service Area, as stated in section 13 (this requirement applies to Spouses and to individuals enrolling in Dependent-only coverage); and
3. The Dependent has been approved by us for enrollment.

See section 8.3 for eligibility requirements for newborn and newly adopted children of existing Members.

8.2.2 Enrollment and Effective Date of Coverage when Applying During Open Enrollment

To obtain coverage, an Eligible Family Dependent must enroll with Providence Health Plan during Open Enrollment. The Open Enrollment period is November 1st through December 15th, with coverage effective January 1st of the following Calendar Year.

To be eligible for an offer of coverage, your application must be submitted by the last day of the Open Enrollment period.
In order for coverage to become effective, we must receive your initial month’s premium in full by the first day of the Plan Year, January 1st.

If your initial month’s premium is not received by January 1st, your application and our offer of coverage are void.

See section 8.3 for Enrollment and Effective Date of Coverage requirements for newborn and newly adopted children of existing Members.

8.3 NEWBORN AND NEWLY ADOPTED CHILDREN ELIGIBILITY AND ENROLLMENT

A newborn or newly adopted child of an existing Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption if the newborn or newly adopted child is enrolled and the additional Premium is paid to us within 60 days of the date of birth or placement for adoption. If the enrollment and payment of the additional Premium due is not accomplished within this time period, no medical Services will be covered for the child. Enrollment after this period is subject to the requirements stated in sections 8.2.

8.4 SPECIAL ENROLLMENT

Providence Health Plan will accept applications for coverage outside of Open Enrollment if the applicant has experienced a Qualifying Event.

Qualifying Events:

a) The person loses minimum essential coverage:
   
   - The person was covered under a COBRA Continuation or State Continuation provision and the coverage under such a provision was exhausted, except when the person failed to pay timely premium, or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact); or
   
   - The person was covered under a group health plan, individual health plan, or other health coverage and the coverage was terminated as a result of:
     
     1. The person’s loss of eligibility for the coverage; including as a result of legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment; except when the person failed to pay timely premium or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact); or
     
     2. The person’s loss of eligibility for coverage under the Children’s Health Insurance Program (CHIP), Medicaid, Medicare, TRICARE, Indian Health Service or domestic or foreign publicly sponsored or subsidized health plan; including but not limited to the Oregon Health Plan (OHP) or Qualified Health Plan coverage through the Oregon Health Insurance Marketplace through the Federal Exchange; or
     
     3. The termination of contributions toward such coverage by the current or former Employer; or
     
     4. The person incurring a claim that exceeds the lifetime limit on benefits.

b) The person previously resided outside of our Service Area and has moved into our Service Area and was covered under another group health plan, individual health plan or other health coverage for at least one day in the previous 60 days.

   - Exceptions to the 60 day requirement:
     
     1. The person moves from out of country back to the United States of America;
     
     2. The person gains status as a lawfully present individual or United States citizen; or
     
     3. The person is released from incarceration.

   - The person gains a Dependent or becomes a Dependent through marriage, birth, adoption, or placement for adoption or foster care.
d) The person becomes eligible for coverage under a state-sponsored or federal-sponsored premium assistance program.

e) The person is subject to a Qualified Medical Child Support Order or other court order requiring medical coverage.

f) The person is a survivor of domestic abuse/violence or spousal abandonment and wants to enroll in a health plan separate from the abuser or abandoner.

Providence Health Plan may modify Special Enrollment provisions consistent with federal or state guidance.

8.4.1 Special Enrollment and Effective Date of Coverage

To obtain coverage due to a Special Enrollment Qualifying Event, you must submit an application for coverage to Providence Health Plan within 60 days of the Qualifying Event. The Effective Date of Coverage is determined by the Qualifying Event as well as Providence Health Plan’s receipt of the application and initial Premium:

- When the Qualifying Event is birth, adoption, or placement for adoption or foster care; coverage will be effective from date of birth or placement for adoption, provided the application and initial Premium is received within 60 days of birth or placement.
- For all other Qualifying Events:
  - If the application is received the 1st of the month through the 15th of the month, coverage will be effective the first day of the following month, provided initial Premium is received by the first day of the effective month.
  - If the application is received the 16th of the month through the end of the month, coverage will be effective the first day of the second following month, provided initial Premium is received by the first day of the effective month.

See section 8.3 for Enrollment and Effective Date of Coverage requirements for newborn and newly adopted children of existing Members.
9. PREMIUM, RENEWAL, REVISION, TERMINATION AND RESCISSION

9.1 PREMIUMS

9.1.1 Premium Billing Information
We will send out Premium billing statements on a monthly basis to the Policyholder listing all Members and the amount of Premium due. If you have selected to pay by automatic credit card payment, you will receive a monthly notice of the amount charged to your account.

9.1.2 Changes in Premium Charges
The Premium may be changed only in accordance with the following provisions:

1. The Premium is subject to change upon renewal of this Contract for another Plan Year.
2. If at any time during a Plan Year any federal or state law or any order or regulation of a federal or state agency mandates a modification of benefits under this Contract, we may change the Premium and/or Covered Services accordingly and notify you of this change in writing. The change in Premium shall be effective on the effective date of the modification of benefits, as stated in the notice.
3. If at any time during a Contract Year any federal or state law enacts a tax or assessment associated with this Group Contract, Providence Health Plan may change the premium. The change in Premium shall be effective on the effective date of the tax or assessment, as stated in the notice.
4. The Premium may be adjusted to reflect changes in your family composition. The change in Premium shall be effective on the first of the month following the change in family composition.
5. Any change in Premium resulting from an approved plan change, as provided in section 9.2, will become effective on the first day of the month that the plan change becomes effective.

9.1.3 Premium Payment Due Date
The Premium is due on the first of the month. If the Policyholder does not pay the Premium within 10 days after the due date, we will mail a single Premium delinquency notice to the Policyholder. If the Policyholder does not pay the Premium by the last day of the grace period specified in the notice, coverage will be terminated, with no further notice to the Policyholder, on the last day of the monthly period through which Premium was paid. We reserve the right to suspend claims processing for Policyholders whose premium is delinquent. Failure to pay the Premium includes making a partial payment of the amount due as Premium. If we fail to send the Premium delinquency notice specified above, we will continue the Contract in effect, without payment of Premium, until we provide such notice.

9.2 CHANGING PLANS
Members who wish to select a different plan option following enrollment may request a plan change when a new Plan Year takes effect. Members may either:

(a) Elect coverage under a plan option with lesser benefits (for example, a plan with a higher Deductible, Coinsurance or Out-of-Pocket Maximum). The request to change plans must be made within 30 days of the start of the new Plan Year and the coverage change will take effect on the first of the month following our receipt of your written request.
(b) Apply for coverage in a plan option with greater benefits (for example, a plan with a lower Deductible, Coinsurance or Out-of-Pocket Maximum). The request to change plans must be made within 30 days of the start of the new Plan Year and must include an updated application for all Members requesting the change. We will review the application(s) and will notify you in writing of our decision. If we approve the request, the coverage change will take effect on the first of the month following our decision. If we deny the request, existing coverage will continue with no change in benefits. Please contact us to request an application to change coverage.


9.2.1 Combining Coverage Under One Plan

Members who are enrolled under separate Contracts may be eligible to combine their coverage under one plan for reasons such as marriage, as follows:

(a) Coverage may be combined under the Contract with lesser benefits (for example, a plan with a higher Deductible, Coinsurance or Out-of-Pocket Maximum). The request to combine coverage must be made in writing and the coverage change will take effect on the first of the month following our receipt of your written request.

(b) Members may apply for coverage to be combined under the Contract with greater benefits (for example, a plan with a lower Deductible, Coinsurance or Out-of-Pocket Maximum). The request to combine coverage must be made in writing and must include an updated application for all Members requesting the change. We will review the application(s) and will notify you in writing of our decision. If we approve the request, the coverage change will take effect on the first of the month following our decision. If we deny the request, existing coverage will continue with no change in benefits. Please contact us to request an application to change coverage.

9.3 RENEWAL AND REVISION

This Contract is guaranteed renewable and will not be terminated due to claims experience, health status, or length of time in force.

We may revise this Contract upon renewal with prior approval from the Oregon Insurance Division and written notice to you at least 30 days prior to the start of a new Plan Year.

We may revise this Contract outside of renewal if required by federal or State mandate. To the extent permissible by such mandate, will provide you with at least 30 days advance written notice of such revision.

Your payment of premium constitutes acceptance of any revisions to the provisions of this Contract that may occur at renewal or outside of renewal as permissible by applicable federal or state law.

9.4 TERMINATION

This Contract may be terminated for any of the following reasons:

1. When the Policyholder fails to pay the Premium by the due date as specified in section 9.1.3.
2. When the Policyholder makes a written request for termination of this Contract. The termination of coverage will be effective on the last day of the monthly period through which Premium was paid.
3. When a Policyholder, enrolled Spouse, or a Member enrolled in Dependent-only coverage ceases to reside in our Oregon Service Area, as described in section 13. The termination of coverage will be effective the last day of the month in which the Member resides in our Oregon Service Area.
4. Upon our discovery of fraud or intentional misrepresentation on the part of the Policyholder or Member.
5. When we cease to offer or elect not to renew all Individual & Family Plans in this state. The termination will be effective on the date specified in the notice from us. This date shall not be earlier than 180 days from the date of the notice.
6. When we cease to offer or elect not to renew an Individual & Family Plan for all individuals in this state. We will send written notice to all Policyholders covered by the affected Plan at least 90 days prior to discontinuation. In addition, we will offer replacement coverage to all affected Policyholders in one of our ongoing Individual & Family Plans.
7. When we cease to offer or elect not to renew an Individual & Family Plan to individuals in a specified Service Area because of an inability to reach an agreement with the health care providers or organization of health care providers to provide Services under this Contract.
within that specified Service Area, we will send written notice to all Policyholders covered by this Contract at least 90 days prior to discontinuation. In addition, we will offer to all affected Policyholders all other Individual & Family Plans that we offer in our Service Area.

8. When we are ordered by the Director to discontinue coverage in accordance with procedures specified or approved by the Director upon finding that the continuation of the coverage would not be in the best interests of our Members or impair our ability to meet contractual obligations.

9. In the case of a plan that delivers Covered Services through a network of Network Providers, when we no longer have any Members living, residing or working in our Service Area.

**9.4.1 Termination Date**

Termination of Member coverage under this Contract will occur on the earliest of the following dates:

1. The date this Contract terminates as specified in this section 9;
2. The last day of the month through which the Premium was paid when the Policyholder requests termination of coverage;
3. For a Policyholder, the last day of the month in which the enrolled Policyholder ceases to reside in our Oregon Service Area, as stated in section 13;
4. For the enrolled Spouse of a Policyholder, the last day of the month in which the enrolled Spouse ceases to resides in our Oregon Service Area, as stated in section 13;
5. For a Dependent child enrolled on a Dependent-only Plan, the last day of the month in which the child ceases to resides in our Oregon Service Area, as specified in section 13;
6. For a Member, the date of disenrollment from this Contract, as described in section 9.4.2; and
7. For a Family Member, the last day of the month in which the individual no longer qualifies as an Eligible Family Dependent.

Enrolled Family Members who no longer meet the definition of Eligible Family Dependent, as specified in section 12, may be eligible to maintain enrollment under a separate policy with no lapse in coverage provided that a completed application and the associated premium is received by us no later than 30 days from the last date of coverage under this Contract.

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

**9.4.2 Disenrollment from this Individual & Family Plan Contract**

“Disenrollment” means that your coverage under this Contract is terminated by us because you have engaged in fraudulent or dishonest behavior, such as:

- You have filed false claims with us;
- You have allowed a non-Member to use your Member ID card to obtain Services; or
- You provided false information on your application for coverage.

**9.4.3 Termination and Rescission of Coverage Due to Fraud or Abuse**

Coverage under this Contract, either for you or for your covered Dependent(s) may be rescinded (meaning your coverage is retroactively canceled) or terminated in case of a fraud or intentional misrepresentation of material fact by you or by your covered dependent in obtaining, or attempting to obtain, benefits under this Individual & Family Plan.

If coverage is rescinded, Providence Health Plan will retain any money you paid for coverage as liquidated damages and will have the right to recover from you or from your covered dependents the
benefits paid as a result of such wrongful activity. We will provide all affected plan participants with a 30 day notice before rescinding your coverage.

9.4.4 Non-Liability After Termination
Upon termination of this Contract, we shall have no further liability beyond the effective date of the termination unless the Member continues, without lapse of membership, under another Providence Health Plan.

9.4.5 Notice of Creditable Coverage
We will provide upon request written certification of the Member’s period of Creditable Coverage when:

- A Member ceases to be covered under this Contract; and
- A Member requests a Notice of Creditable Coverage within 24 months of the termination of coverage.
10. MEMBER RIGHTS AND RESPONSIBILITIES

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

Members have the right to:

- Be cared for by people who respect your privacy and dignity.
- Be informed about Providence Health Plan, our providers, and the benefits and Services you have available to you as a Member.
- Receive information that helps you select a Qualified Practitioner whom you trust and with whom you feel comfortable.
- A candid discussion of appropriate or Medically Necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Receive information and clinical guidelines from your health care provider or your health plan that will enable you to make thoughtful decisions about your health care.
- Actively participate in decisions that relate to your health and your medical care through discussions with your health care provider or through written advance directives.
- Have access to medical Services that are appropriate for your needs.
- Express a concern or an Appeal 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.
- Be informed about and make recommendations regarding Providence Health Plan’s member rights and responsibilities policy.
- Refuse care from specific providers.

Members have the responsibility to:

- Read and understand the information in and the terms of your Contract. We will have no liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact us. We will assist you in understanding and complying with the terms of the Plan.
- Talk openly with your physician or provider, understand your health problem and work toward a relationship built on mutual trust and cooperation.
- Develop mutually agreed upon treatment goals with your Qualified Practitioner, to the degree possible, and follow treatment plans and instructions.
- Supply to the extent possible information Providence Health Plan and your physicians or providers need to provide care.
- 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.
- Call or write within 180 days of Service if you wish to request a review of Services provided or Appeal a Providence Health Plan decision.
- Notify Customer Service if your address changes.
**Providence Health Plan has the responsibility to:**

- Respect and honor your rights.
- Ensure timely access to appropriate health care Services.
- Enable you to see physicians or providers who meet your needs.
- Develop a variety of benefits to serve you well.
- Assure the ongoing quality of our providers and Services.
- Contract with providers who are capable, competent, and committed to excellence.
- Make it easy and convenient for you to Appeal any policy or decision that you believe prevents you from receiving appropriate care.
- Provide you with accurate up-to-date information about Providence Health Plan and Network 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.
11. GENERAL PROVISIONS

11.1 AMENDMENT OF PLAN
The provisions of this Contract may be amended, subject to receiving any required regulatory approval(s), by agreement between the State of Oregon and us. Any such amendment shall become effective on the date specified in the amendment. The payment of Premium for any period of coverage after the effective date of an amendment shall constitute the acceptance of the amendment by the Policyholder if we have provided written notice of the amendment to the Policyholder prior to the payment of such Premium. Outside of renewal or as required by Oregon state or federal mandate, no material modification will be made to benefits, including preventive benefits, without providing notice to Members 60 days in advance of the effective date.

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

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

11.4 CHOICE OF STATE LAW
The laws of the State of Oregon govern the interpretation of this Contract and the administration of benefits to Members.

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

11.6 DUTY TO COOPERATE AND TO PROVIDE RELEVANT INFORMATION
The Policyholder and all Members are required to cooperate with us in all manners reasonably related to securing any Member’s rights, or our rights, under this Contract, including but not limited to providing, upon request, all information relevant to eligibility, to coverage, to coordination of benefits, or to third-party or subrogation matters. Policyholders warrant that all information contained in applications, questionnaires, forms, or statements submitted to us is true, correct, and complete. If any Member fails to provide information required to be provided under this Contract or knowingly provides incorrect or incomplete information, then the rights of that Member, and of any Family Members may be terminated as described in section 9.4.

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

11.8 INFORMATION AVAILABLE UPON REQUEST

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

- Company 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 503-947-7984 or by writing to:

Oregon Insurance Division,
Consumer Protection Unit,
350 Winter Street NE, Room 440-2,
Salem, OR 97301-3883.

You also can contact them through their website at www.cbs.state.or.us/ins/.

11.9 INTEGRATION

This Contract, consisting of this document, the Benefit Summary and any Supplemental Benefit Summary, and any Endorsement or amendments to those documents, embodies the entire Contract of the parties. There are no promises, terms, conditions or obligations other than those contained herein. This Contract shall supersede all other communications, representations or agreements, either verbal or written, between the parties.

11.10 LEGAL ACTION

No legal proceeding may be brought to recover benefits from this Contract until receipt of a final decision from the Providence Health Plan Grievance Committee. After such a decision, an Appeal may lie with an Independent Review Organization (IRO). In the event a right to IRO review exists and you elect to seek such review, it will be binding and final, both on you and on Providence Health Plan. All other challenges to the final decision of the Grievance Committee must be brought in Oregon state court, either in your county of residence or such other county as mutually agreed upon between you and the Plan. In the alternative, you may request that the Plan agree to submit the dispute to binding arbitration before a single arbitrator under the rules of the United States Arbitration & Mediation Service in your county of residence or such other county as mutually agreed upon between you and the Plan. Any such arbitration shall be under Oregon law, in accordance with USA&M’s Rules for Arbitration, and the arbitrator’s decision shall be final and legally binding and judgment may be entered thereon. No such action may be brought later than three years after the Grievance Committee’s decision was issued. Irrespective of whether the Grievance is appealed to a court or an arbitrator, neither party shall, under any circumstance, be liable to the other for any special, incidental or consequential damages, or for any tort liability (including any punitive or exemplary damages), in any way related to this Contract.
11.11 MEMBER RESPONSIBILITY
It is your responsibility to read and to understand the terms of this Contract. We will have no liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Contract. If you have any questions or are unclear about any provision concerning this Contract, please contact us. We will assist you in understanding and complying with the terms of this Contract.

11.12 MEMBER ID CARD
The Member ID card is issued by Providence Health Plan for Member identification purposes only. It does not confer any right to Services or other benefits under this Contract.

11.13 NON-TRANSFERABILITY OF BENEFITS
No person other than a Member is entitled to receive benefits under this Contract. Such right to benefits is nontransferable.

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

11.15 NO RECOLLSE FOR ACTS OF PROVIDERS
The Hospitals, Skilled Nursing Facilities, physicians and other persons or organizations providing Services to you do so as independent contractors. We are not liable for any claim or demand due to damages arising out of or in any manner connected with any injuries suffered by you while receiving such Services.

11.16 NO REINSTATEMENT BY ACCEPTANCE OF PAYMENT
If this Contract is terminated for any reason, our acceptance of Premium after notice of the termination shall not guarantee a reinstatement of this Contract. Any reinstatement must be agreed to by both us and the Policyholder. We shall refund any payment we accepted, less any outstanding balance, to the Policyholder upon discovery that the payment was accepted without mutual agreement to reinstate.

11.17 NOTICE
Any notice required of us under this Contract shall be deemed to be sufficient if mailed to the Policyholder by postal or electronic means at the address appearing on the records of Providence Health Plan. Notices of termination of health insurance coverage will not be sent by electronic means. Any notice required of you shall be deemed sufficient if mailed by postal or electronic means to the principal office of Providence Health Plan, P.O. Box 3125, Portland, OR 97208 or via the contact link provided on our website at ProvidenceHealthPlan.com.

11.18 PHYSICAL EXAMINATION AND AUTOPSY
We, at our own expense, shall have the right and opportunity to examine any Member when and as often as it may reasonably require during the pendency of any claim covered by this Contract. We also have the right to make an autopsy in case of death if not forbidden by law.
11.19 PREMIUM REBATES
If applicable, we will issue premium rebates in accordance with federal Medical Loss Ratio requirements directly to the Policyholder for any Members covered under this Individual & Family Plan.

11.20 PROFESSIONAL REVIEW AND RIGHT TO EXAMINE RECORDS
All Members, by acceptance of the benefits of this Contract, shall be deemed to have consented to the examination of medical records for purposes of utilization review, quality assurance and peer review by Providence Health Plan or our designee.

All Members, for purposes other than utilization review, quality assurance and peer review, may be required to authorize any provider to give and discuss with us any information relating to any condition for which benefits are claimed under this Contract. We may transfer this information between providers or other organizations who are treating you or performing a Service on our behalf.

If you do not consent to the release of records or to discussions with providers, we will be unable to determine the proper payment of any benefits and will deny the claims accordingly. Consent to the release of records and discussion with providers is a condition of payment of any benefits. Neither the consent to, nor the actual examination of the records or discussion with providers will constitute a guarantee of payment.

11.21 PRORATION OF BENEFITS
Benefits are based on a Calendar Year. If the benefits under this Contract are modified, or if you change to another Contract within Providence Health Plan, the benefit limits shall be prorated accordingly.

11.22 PROVIDER PAYMENTS
Providence Health Plan pays Network 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 Primary Care Providers and other providers to give members quality care and to keep health care costs within budget.

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

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

11.24 SUGGESTIONS
You are encouraged to make suggestions to us. Suggestions may be oral or written and should be directed to a Customer Service representative at our administrative office.

11.25 WORKERS’ COMPENSATION INSURANCE
This Contract is not in lieu of, and does not affect, any requirement for coverage under any Workers’ Compensation Act or similar law.
12. DEFINITIONS

The following are definitions of important terms used in this Individual & Family Plan Contract and appear throughout as Capitalized text.

**Adverse Benefit Determination**
See section 7.

**Alternative Care Provider**
Alternative Care Provider means a naturopath, chiropractor, acupuncturist or massage therapist who is professionally licensed by the appropriate governmental agency to diagnose or treat an injury or illness and who provides Covered Services within the scope of that license.

**Ambulatory Surgery Center**
Ambulatory Surgery Center means an independent medical facility that specializes in same-day or outpatient surgical procedures.

**Appeal**
See section 7.

**Approval Notice**
Approval Notice means the electronic or written communication sent by Providence Health Plan indicating that you and/or your Eligible Family Dependent(s) have been approved for coverage under this Contract.

*Note: The Approval Notice is not a guarantee of coverage under this Contract. In order for coverage to become effective, you must remit the initial premium within the time period specified in the Approval Notice.*

**Approved Clinical Trial**
Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment or cancer or other life-threatening disease or condition and is one of the following:
- A federally funded or approved trial;
- A clinical trial conducted under an FDA investigational new drug application; or
- A drug trial that is exempt from the requirement of an FDA investigational new drug application.

**Authorized Representative**
See section 7.

**Benefit Summary**
Benefit Summary means the document with that title which is part of this Individual & Family Plan Contract and which summarizes the benefit provisions under this Contract.

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

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

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

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

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

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

**Covered Service**
Covered Service means a Service that is:
- Listed as a benefit in the Benefit Summary and in section 4;
- Medically Necessary;
- Not listed as an Exclusion in the Benefit Summary or in sections 4 and 5; and
- Provided to you while you are a Member and eligible for the Service under this Contract.

**Custodial Care**
Custodial Care means Services that:
- Do not require the technical skills of a licensed nurse at all times;
- Include, but are not limited to, assistance with dressing, bathing, eating, ambulation, taking medication and incontinence care; and
- Are not likely to improve your medical condition.

Such Services will still be considered Custodial Care even if:
- You are under the care of a physician;
- The Services are prescribed by a Qualified Practitioner;
- The Services function to support or maintain your condition; or
- The Services are being provided by a registered nurse or licensed practical nurse.

**Deductible**
See section 3.12.1.

**Dependent-only Plan**
Dependent-only Plan means a Contract covering only a Dependent child under 21 years of age (age 0-20 years).
**Dependent**
Dependent means a person who is supported by the Policyholder, or supported by the Policyholder’s Spouse or Domestic Partner. See also Eligible Family Dependent.

**Director**
Director means the Director of the Oregon Division of Financial Regulation.

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

Note: All provisions of this Contract that apply to a Spouse shall apply to a Domestic Partner.

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

**Effective Date of Coverage**
Effective Date of Coverage means the date upon which coverage under this Contract commences for a Member.

**Eligible Family Dependent**
Eligible Family Dependent means:
1. The legally recognized Spouse or Domestic Partner of a Policyholder;
2. In relation to a Policyholder, the following individuals:
   - A biological child, step-child, or legally adopted child;
   - An unmarried grandchild for whom the Policyholder or Spouse provides at least 50% support;
   - A child placed for adoption with the Policyholder or Spouse;
   - An unmarried child for whom the Policyholder or Spouse is a legal guardian and for whom the Policyholder or Spouse provides at least 50% support; and
   - A child for whom the Policyholder or Spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law.

Placement for adoption means the assumption and retention by a Policyholder or Spouse or Domestic Partner, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption). The child’s placement with a Policyholder or Policyholder’s legally recognized Spouse terminates upon any termination of such legal obligations.

The limiting age for each Dependent child who is enrolled as an Eligible Family Dependent is age 26 and such Members shall become ineligible for coverage under this Contract on the last day of the month in which their 26th birthday occurs, except:

- When an Eligible Family Dependent is enrolled on a Dependent-only Plan, the limiting age is 20, and such a Member shall become ineligible for coverage under this Contract on the last day of the month in which their 21st birthday occurs.
Enrolled Eligible Family Dependents who become ineligible for coverage under this Contract may be eligible to continue coverage under a separate Contract as specified in section 9.4.

A covered Dependent child who attains the limiting age remains eligible if the child is:
1. Developmentally or physically disabled;
2. Incapable of self-sustaining employment; and
3. Unmarried.

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

**Emergency Medical Condition**
See section 4.5.1.

**Emergency Medical Screening Exams**
See section 4.5.1.

**Emergency Services**
See section 4.5.1.

**Essential Health Benefits**
Essential Health Benefits means the general categories of services established under section 1302(b) of the Patient Protection and Affordable Care Act (PPACA) and applicable regulations:
- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental Health and substance use disorder (Chemical Dependency) services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including dental and vision care.

**E-visit**
E-visit (electronic provider communications) means a consultation through e-mail with a Network Provider that is, in the judgment of the Network Provider, Medically Necessary and appropriate and involves a significant amount of the Network Provider’s time. An E-visit must relate to the treatment of a covered illness or injury (see also section 4.1.2).

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

**Family Member**
Family Member means an Eligible Family Dependent who is properly enrolled in and entitled to Services under this Contract. A Dependent-only Family Member means an Eligible Family Dependent, of a non-enrolled Policyholder, who is under age 21 when enrollment commences in this Contract.

**Grievance**
See section 7.

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

**Hospital**
Hospital means an institution which:
- Maintains permanent full-time facilities for bed care of resident patients;
- Has a physician or surgeon in regular attendance;
- Provides continuous 24 hour-a-day nursing Services;
- Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
- Is legally operated in the jurisdiction where located; and
- Has surgical facilities on its premises or has a contractual agreement for surgical Services with an institution having a valid license to provide such surgical Services.

Hospital does NOT include an institution that is principally a rest home, nursing home, Skilled Nursing Facility, convalescent home or home for the aged. Hospital does NOT include a place principally for the treatment of alcohol or Chemical Dependency or Mental Health disorders.

**Individual Application**
Individual Application means the electronic or paper document created by us that must be completed by an individual seeking coverage under this Individual & Family Plan Contract.

**Individual & Family Plan Contract**
Individual & Family Plan Contract, also referred to as Contract, means the provisions of this Individual & Family Plan document, the Benefit Summary, any endorsements or amendments to those documents, and those policies maintained by Providence Health Plan which clarify any of those documents.

**In-Network**
In-Network means the level of benefits specified in the Benefit Summary for Covered Services that are provided by a Medical Home or by Medical Home Referral to a Network Provider.

**Medical Home**
Medical Home means one of the special clinics located within the Providence Connect Network that has agreed to provide services and coordinate care for Members under this Plan.
Medical Home Referral
Medical Home Referral means a referral by a Medical Home for a Member to receive services from a Network Provider outside of the Medical Home. To be eligible for coverage, any services received as a result of the referral must qualify as Medically Necessary Covered Services under this Plan. Prior Authorization applies.

Medically Necessary
Medically Necessary means Services that are in the reasonable opinion of Providence Health Plan, consistent with the written criteria regarding medically indicated Services that are maintained by us. The criteria are based on the following principles:

1. The Service is medically indicated according to the following factors:
   a. The Service is necessary to diagnose or to meet the reasonable health needs of the Member;
   b. The expected health benefits from the Service are clinically significant and exceed the expected health risks by a significant margin;
   c. The Service is of demonstrable value and that value is superior to other Services and to the provision of no Services; and
   d. Expected health benefits can include:
      o Increased life expectancy;
      o Improved functional capacity;
      o Prevention of complications; or
      o Relief of pain.
2. The Qualified Practitioner recommends the Service.
3. The Service is rendered in the most cost-efficient manner and type of setting consistent with nationally recognized standards of care, with consideration for potential benefits and harms to the patient.
4. The Service is consistent in type, frequency and duration with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by us.

In the case of a life-threatening illness, a Service that would not meet the criteria above may be considered Medically Necessary for purposes of reimbursement, if:
- It is considered to be safe and effective, as demonstrated by accepted clinical evidence reported by generally-recognized medical professionals or publications; and
- The treatment is provided in a clinically controlled research setting using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health for a life-threatening condition.

For the purpose of this exception, the term “life-threatening” means more likely than not to cause death within one year of the date of the request for diagnosis or treatment.

Member
Member means a Policyholder or Eligible Family Dependent who is properly enrolled in and entitled to Services under this Contract.

Mental Health
Mental Health means any mental disorder covered by diagnostic categories listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), such as but not limited to major depressive disorder, autism spectrum disorder, dissociative identity disorder, gender dysphoria, and substance use disorder.
**Network Pharmacy**

Network Pharmacy means a pharmacy that has signed a contractual agreement with Providence Health Plan to provide medications and other Services at special rates. There are four types of Network Pharmacies:

1. Retail: a Network Pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions.
2. Preferred Retail: a Network Pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.
3. Specialty: a Network Pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.
4. Mail Order: a Network Pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.

**Network Provider**

Network Provider means an Outpatient Surgical Facility, Home Health Provider, Hospital, Qualified Practitioner, Qualified Treatment Facility or Skilled Nursing Facility that has a written agreement with Providence Health Plan to participate as a health care provider for this Plan. For Native American Indian and Alaskan Native Members, Covered Services obtained through Indian Health Services are considered to be Covered Services obtained from a Network Provider.

**Out-of-Network Provider**

Out-of-Network Provider means an Outpatient Surgical Facility, Home Health Provider, Hospital, Qualified Practitioner, Qualified Treatment Facility, Skilled Nursing Facility, or Pharmacy that does not have a written agreement with Providence Health Plan to participate as a health care provider for this Plan.

**Out-of-Pocket Maximum**

See section 3.12.2.

**Outpatient Surgical Facility**

Outpatient Surgical Facility means any licensed public or private establishment that has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgery. It does NOT provide Services or accommodations for patients to stay overnight.

**Participating Dentist**

Participating Dentist shall mean those independent licensed dentists and licensed expanded practice dental hygienists who have contracted with the Plan to provide dental services at negotiated fees for Members of the Plan. Participating Dentists are not employers of nor supervised by the Plan.

**Plan Year**

Plan Year means the 12-month period for which Premium rates for this Contract have been approved by the Director. The Plan Year begins on January 1.

**Policyholder**

Policyholder means the person to whom this Contract has been issued. A policyholder shall be age 18 or older. If enrollment under this Contract consists solely of one child who is under age 21, the adult person who applied for such coverage shall be deemed to be the Policyholder until such child reaches the age of 21 when this Contract shall be reissued to show the 21 year old Member as the Policyholder.
**Premium**
Premium means the monthly rates set by us and approved by the Director as consideration for benefits offered under this Contract. Premium rates are subject to change at the beginning of each Plan Year.

**Primary Care Provider**
Primary Care Provider means a Qualified Practitioner 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 care by serving as case manager. Members may choose a Qualified Practitioner specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women’s health care as their Primary Care Provider. (Note: Not all Qualified Practitioners are Primary Care Providers. To obtain a listing of Network Primary Care Providers please see the Online Network Provider Directory or call Customer Service.)

**Prior Authorization**
Prior Authorization or Prior Authorized means a request to us by you or by a Qualified Practitioner regarding a proposed Service, for which our prior approval is required. Prior Authorization review will determine if the proposed Service is eligible as a Covered Service or if an individual is a Member at the time of the proposed Service. To facilitate our review of the Prior Authorization request, we may require additional information about the Member’s condition and/or the Service requested. We may also require that a Member receive further evaluation from a Qualified Practitioner of our choosing. Prior Authorization is subject to the terms and provisions of this Contract. Services that require Prior Authorization are stated in section 3.6.

Prior Authorized determinations are not a guarantee of benefit payment unless:
- A determination that relates to benefit coverage and medical necessity is obtained no more than 30 days prior to the date of the Service; or
- A determination that relates to eligibility is obtained no more than five business days prior to the date of the Service.

**Providence Connect Network**
Providence Connect Network means the special network of Medical Homes and Providers that have agreed to provide Covered Services for Members of this Plan.

**Providence Health Plan**
Providence Health Plan means the nonprofit corporation authorized as a health care service contractor in the state of Oregon that issues this Individual & Family Plan Contract to the Policyholder.

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

**Qualified Treatment Facility**
Qualified Treatment Facility means a facility, institution or clinic duly licensed by the appropriate governmental agency, which is primarily established and operating within the lawful scope of its license.
Reconstructive Surgery
Reconstructive Surgery means surgery that restores features damaged as a result of injury or illness or to correct a congenital deformity or anomaly that results in functional impairment.

Retail Health Clinic
Retail Health Clinic means a walk-in clinic located in a retail setting such as a store, supermarket or pharmacy that treats uncomplicated minor illnesses and injuries.

Service
Service means a health care related procedure, surgery, consultation, advice, diagnosis, referrals, treatment, supply, medication, prescription drug, device or technology that is provided to a Member by a Qualified Practitioner.

Service Area
See section 13.

Skilled Nursing Facility
Skilled Nursing Facility means a convalescent or chronic disease facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or certified as a “Skilled Nursing Facility” by the Secretary of Health and Human Services pursuant to Title XVIII of the Social Security Act as amended.

Spouse
Spouse means an individual who is legally married to the Policyholder in accordance with the laws of the country or state of celebration.

Urgent Care
Urgent Care means Services that are provided for unforeseen, non-life threatening, minor illnesses and injuries which require immediate attention such as ear, nose and throat infections and minor sprains and lacerations.

Urgent Care Covered Services are provided when your medical condition meets the guidelines for Urgent Care that have been established by us. Covered Services do NOT include Services for the inappropriate use of an Urgent Care facility, such as: Services that do not require immediate attention, routine check-ups, follow-up care, and prescription drug requests.

Usual, Customary and Reasonable (UCR)
When a Service is provided by a Network Provider UCR means charges based on the fee that we have negotiated with Network Providers for that Service. UCR charges will never be less than our negotiated fees.

When a Service is provided by an Out-of-Network Provider, UCR charges will be determined, in Providence Health Plan's reasonable discretion, based on the lesser of:

1. The fee a professional provider usually charges for a given Service;
2. A fee which falls within the range of usual charges for a given Service billed by most professional providers in the same locality or region who have similar training and experience;
3. A fee which is prevalent or which would not be considered excessive in a particular case because of unusual circumstances; or
4. The fee determined by comparing charges for similar Services to a regional or national database adjusted to the geographical area where the Service was performed.
UCR charges do not include sales taxes, handling fees and similar surcharges and such taxes, fees and surcharges are not covered expenses.

**Virtual Visit**
Virtual Visit means a visit with a Network Provider using secure internet technology:

- **Phone and Video Visit**
  Phone and Video Visit means a Medically Necessary and appropriate consultation through phone and video with a Network Provider using Providence Health Plan approved secure technology. A Phone and Video Visit must relate to the treatment of a covered illness or injury (see also section 4.3.2).

- **Web-direct Visit**
  Web-direct Visit means a Medically Necessary consultation with a Network Provider utilizing an online questionnaire to collect information and diagnose common conditions such as cold, flu, sore throat, allergy, earache, sinus pain or UTI (see also section 4.3.2).

**Women’s Health Care Provider**
Women’s Health Care Provider means an obstetrician or gynecologist, some Primary Care Providers and naturopaths (if they are licensed to provide obstetrical services), physician assistant specializing in women’s health, advanced registered nurse practitioner specialist in women’s health, certified nurse midwife, or licensed direct entry midwife, practicing within the applicable lawful scope of practice.
13. SERVICE AREA

Service Area means the geographic area in Oregon within which the Policyholder, the Spouse, or the Dependent-only Member must physically reside in order to be eligible for coverage under this Contract.

Medical Homes and Network Providers are located within the Providence Connect Service Area.

All ZIP codes in the following Oregon counties:

Clackamas
Hood River
Multnomah
Washington

Selected ZIP code in the following Oregon county:

Yamhill
97132
Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:
- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCION: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüistica. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711)번으로 전화해 주십시오.

УВАГА! Якщо ви говорите українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711)まで、お電話にてご連絡ください。

MLHOZTE: إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 4445-878-800-1.

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).


ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).