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Providence Health Plan
2
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 Individual & Family Plan Contract.

- Some capitalized terms have special meanings in this contract. Please see section 12, Definitions.
- In this Individual Contract, Providence Health Plan is referred to as “we,” “us” or “our.” Members enrolled under this Individual Contract are referred to as “you” or “your.”
- This Individual Contract includes this document, the Benefit Summary, and any endorsements or amendments that accompany this document. If after examining this Individual 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 Open Option Plan is provided through:
  - Our network of Participating Providers located in our Service Area;
  - Our national network of Participating Providers; and
  - Non-Participating Providers.
- All Members are encouraged to choose a Personal Physician/Provider who will provide preventive and primary care Services and coordinate other care in a convenient and cost-effective manner.
- With an Open Option Plan, Members will have lower out-of-pocket expenses when they obtain Covered Services from Participating Providers. Members may, however, obtain Covered Services from Non-Participating Providers, but that option will result in higher out-of-pocket expenses for most Covered Services. Please see section 2 and the Benefit Summary for additional information.
- The following Services are covered only under the In-Plan benefits, as specified in the Benefit Summary:
  - All E-visit Services (see section 5.1.2)
  - All Tobacco Use Cessation Services (see section 6.7)
  - All Outpatient Prescription Drugs (see section 5.8)
  - All Human Organ/Tissue Transplants (see section 6.1)
- Certain Covered Services require an approved Prior Authorization, as stated in section 4.5.
- For members age 19 and older, most Covered Services are subject to a Pre-existing Conditions Exclusion, as stated in sections 4.11 and 12.
- Human organ/tissue transplants and elective procedures are subject to Exclusion Periods, as stated in section 4.10.
- Coverage limitations and exclusions apply to certain Services, as stated in sections 4, 5, 6 and 7 and the Benefit Summary.
- Coverage under this Individual Contract is available 24 hours a day, seven days a week and during periods of domestic or foreign travel.
- Enrolled Policyholders, enrolled Dependent spouses and Dependent children enrolled on Dependent-only Individual Contracts must reside in our Oregon Service Area, as specified in section 13.
- A printed directory of Participating Providers in our Service Area is available to all Members. Online access to Participating Providers in our Service Area and our national network of Participating Providers is available at: www.ProvidenceHealthPlan.com. If you do not have Internet access and would like a printed listing of Participating Providers from our national network, please contact us directly and we will send you a printed listing of the Participating Providers located in the area(s) you request.
2. WELCOME TO PROVIDENCE HEALTH PLAN

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

2.1 YOUR OPEN OPTION PLAN

Your Open Option Plan allows you to receive Covered Services from Participating Providers through what is called your In-Plan benefit. You also have the option to receive most Covered Services from Non-Participating Providers through what is called your Out-of-Plan benefit. Generally, your out-of-pocket costs will be less when you receive Covered Services from Participating Providers. Also, Participating Providers will work with us to Prior Authorize treatment. If you receive Covered Services from Non-Participating Providers, it is your responsibility to make sure the Services listed in section 4.5 are Prior Authorized by us before treatment is rendered.

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

If you are unsure about a physician/provider’s, hospital’s or other facility’s participation with Providence Health Plan, visit our Provider Directory, available online for Open Option Plan Members at www.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 Covered Services.

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

This 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 13. If you need additional help understanding anything in this document, please call Customer Service at 503-574-7500 or 1-800-878-4445. See section 2.3 for additional information on how to reach Customer Service.

This Individual & Family Plan Contract is not complete without your:
- Open Option Benefit Summary which is available at www.ProvidenceHealthPlan.com when you register for a myProvidence account as explained in section 2.4. The Benefit Summary details your Copayments and Coinsurance for Covered Services.
- Provider Directory which lists Participating Providers, available online at www.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: 1-800-878-4445.
- Members with hearing impairment, please call the TTY line: 503-574-8702 or toll-free 1-888-244-6642.

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

2.4 REGISTERING FOR A MyPROVIDENCE ACCOUNT

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

2.5 YOUR MEMBER ID CARD

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

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

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

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

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

- Visit your health care provider or facility.
- Call for Mental Health/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 RN

Providence RN — 503-574-6520; toll-free 1-800-700-0481; TTY 1-800-735-2900

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

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

Please have your Member ID Card available when you call.
3. 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 Individual Contract. You must provide us with evidence of eligibility as requested.

3.1 POLICYHOLDER ELIGIBILITY AND ENROLLMENT

3.1.1 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 has completed the Oregon Standard Health Statement; and
3. The individual resides in our Oregon Service Area as stated in section 13; and
4. The individual has been approved by us for enrollment.

3.1.2 Enrollment and Effective Date of Coverage
To obtain coverage, an Eligible Individual must enroll with Providence Health Plan by remitting the initial Premium within the time period specified in the Approval Notice after meeting the requirements stated in section 3.1.1.

Your Effective Date of Coverage will be the earlier of the 1st of the month or the 15th of the month following our receipt of your initial Premium. You may request to delay your Effective Date, however, your requested Effective Date must:
- be later than the date we receive your initial Premium;
- be within 70 days of the date your Application was signed; and
- coincide with either the 1st or the 15th of the month.

3.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

3.2.1 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 has completed the Oregon Standard Health Statement; and
3. The Dependent resides in our Oregon Service Area, as stated in section 13 (this requirement applies to Dependent spouses and to Dependent children enrolled on Dependent-only Individual Contracts); and
4. The Dependent has been approved by us for enrollment.

See section 3.3 for eligibility requirements for newborn and newly adopted children of existing Members.

3.2.2 Enrollment and Effective Date of Coverage
To obtain coverage, an Eligible Family Dependent must enroll with Providence Health Plan by remitting the initial Premium within the time period specified in the Approval Notice after meeting the requirements stated in section 3.2.1.

The Effective Date of Coverage will be the earlier of the 1st of the month or the 15th of the month following our receipt of the Eligible Family Dependent’s initial Premium. You may request to delay the Effective Date of an Eligible Family Dependent as stated in section 3.1.2. See section 3.3 for Enrollment and Effective Date of Coverage requirements for newborn and newly adopted children of existing Members.
3.3 NEWBORN AND NEWLY ADOPTED CHILDREN ELIGIBILITY AND ENROLLMENT

A newborn or newly adopted child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption 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 3.2.

3.4 PREMIUMS

3.4.1 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.

3.4.2 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 Individual 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 Individual 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. The Premium may be adjusted to reflect the age changes of you or your enrolled Dependents, or to reflect changes in your family composition. The change in Premium shall be effective on the first of the month following the change in age or family composition.

3.4.3 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 Individual Contract in effect, without payment of Premium, until we provide such notice.

3.5 TERMINATION OF MEMBER COVERAGE

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

1. The date this Individual Contract terminates as specified in section 10;
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 Dependent 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 Individual Contract, as described in section 3.5.1; 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 Individual 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.

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

- You have filed false claims with us;
- You have committed an act of physical or verbal abuse that poses a threat to providers, to other Members, or to Providence Health Plan employees;
- 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.

3.5.2 Non-Liability after Termination
Upon termination of this Individual 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.

3.5.3 Notice of Creditable Coverage
We will provide written certification of the Member's period of Creditable Coverage when:

- A Member ceases to be covered under this Individual Contract; and
- A Member requests a Notice of Creditable Coverage within 24 months of the termination of coverage.
4. HOW TO USE YOUR PLAN

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

4.1 PARTICIPATING PROVIDERS

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

4.1.1 Nationwide network of Participating Providers

Providence Health Plan also has contractual arrangements with certain physicians/providers, hospitals and facilities located outside our Oregon Service Area. These arrangements allow you to receive Services from Participating Providers even when you are outside of our Oregon Service Area.

4.1.2 Choosing a Participating Provider

To choose a Participating Provider, or to verify if a provider is a Participating Provider go to our Online Participating Provider Directory at www.ProvidenceHealthPlan.com and select as your plan type “Open Option Providers.”

If you do not have access to our Web site, please call your Customer Service team to request Participating Provider information.

Your Participating Provider will work with Providence Health Plan to arrange for any prior authorization requirements that may be necessary for certain Covered Services. For more information on Prior Authorization, see section 4.5.

4.2 THE ROLE OF A PERSONAL PHYSICIAN/PROVIDER

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

4.2.1 Personal Physician/Providers

A Personal Physician/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. Adult female Members also 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 Personal Physician/Provider.

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

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

4.3 SERVICES PROVIDED BY NON-PARTICIPATING PROVIDERS

As an Open Option Plan member, you may choose to receive Covered Services from Non-Participating Providers using your Out-of-Plan benefit.

Benefits for Covered Services by a Non-Participating Provider will be provided as shown in the Benefit Summary. See section 4.5 for Prior Authorization requirements.

Generally, when you receive Services from Non-Participating Providers, your Copayments and Coinsurance will be higher than when you see Participating Providers.

When you use Non-Participating Providers, we provide benefits for Medically Necessary Covered Services only when the Services are received from Qualified Practitioners and Qualified Facilities. See section 12 for the definition of Qualified Practitioner and Qualified Facility.

IMPORTANT NOTE: While Providence Health Plan will provide reimbursement for Covered Services received from Non-Participating Providers, the following Services are only covered under your In-Plan benefit from Participating Providers:

- E-visits (see section 5.1.2)
- All outpatient Prescription Drug Services (see section 5.8)
- All Human Organ/Tissue Transplants (see section 6.1)

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

After you meet your Deductible, we will provide payment to Non-Participating Providers for Covered Services according to Usual, Customary and Reasonable charges (UCR). UCR charges do not include sales taxes, handling fees and similar surcharges; such taxes, fees and surcharges are not covered expenses. Charges which exceed UCR are the Member’s responsibility and are not applied to the Out-of-Pocket Maximum. See section 12 for the definition of UCR.

Should you choose to receive Services from a Non-Participating Provider you will be responsible for costs that are not covered or allowed by your Out-of-Plan benefits as shown in the following example.

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

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

4.5 PRIOR AUTHORIZATION

While Prior Authorization is a requirement for coverage of certain Services under this Individual 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 his/her provider and is separate from the Prior Authorization requirements of this Individual Contract. Further, Prior Authorization is not a guarantee of benefit payment under this Individual Contract and a Prior Authorization determination does not supersede other specific provisions of this Individual Contract regarding coverage, limitations, exclusions and Medically Necessary Services.

IN-PLAN SERVICES: Participating Providers are responsible to contact us to obtain Prior Authorization.

OUT-OF-PLAN SERVICES: The Member or the Non-Participating Provider must contact us to obtain Prior Authorization for the following Covered Services. Failure to obtain a required Prior Authorization will result in denial of coverage.

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 inpatient and outpatient Mental Health and Alcoholism Treatment Services, as stated in sections 6.3 and 6.4;
- All human organ/tissue transplant related Services, as stated in section 6.1;
- All PET, CT, CTA, MRI and MRA imaging and Nuclear Cardiac Study Services, as stated in section 5.7.5;
- All home health care Services, as stated in section 5.7.6;
- All hospice Services, as stated in section 5.7.7;
- All medical supplies/devices, prosthetic devices and Durable Medical Equipment in excess of $1,500, as stated in section 6.2;
- All outpatient hospitalization and anesthesia for dental Services, as stated in section 6.5; and
- All cardiac rehabilitation Services, as stated in section 5.4.

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 your Customer Service representative 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-Plan Services:
The Member or the Non-Participating Provider should 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.

4.6 MEDICAL COST MANAGEMENT

Coverage under this Individual 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 Individual Contract. Substituted Services must:

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

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

Coverage of New Technology and New Application of Existing Technology

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.
4.7 MEDICALLY NECESSARY SERVICES

We believe our Members are entitled to comprehensive medical care within the standards of good medical practice. Services must be Medically Necessary as defined in section 12 and as determined by our medical directors and special committees of Participating Providers. General guidelines for determining whether a Service is Medically Necessary include:

- All medical Services that are appropriate and necessary for the diagnosis and treatment of symptoms, illness, disease, injury or condition that is harmful or threatening to your life or health.
- Services that are within the standard of good medical practice within the organized medical community.
  
  Example: Your provider suggests a treatment using a machine that has not been approved for use in the United States. We probably would not pay for that treatment.
- Services at the most appropriate level that can safely be provided.
  
  Example: You go to a hospital emergency room to have stitches removed, rather than wait for an appointment in your doctor’s office. We would not pay for that visit.
- Services that are primarily for your convenience or the convenience of your provider, hospital or any other health care provider.
  
  Example: You stay an extra day in the hospital only because the relative who will help you during recovery can’t pick you up until the next morning. We may not pay for the extra day.

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

4.8 HOW BENEFITS ARE APPLIED

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

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

4.9 DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS

Your Open Option Plan has Individual and Family Deductibles; it also has Individual and Family Out-of Pocket Maximums.

4.9.1 Understanding Deductibles

Your Deductible is the dollar amount that you are responsible to pay for Covered Services every calendar year before benefits are provided by Providence Health Plan. Deductible amounts are payable to your Qualified Practitioner after we have processed your claim.

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

Individual Deductible: An individual Deductible is the amount shown on the Benefit Summary that must be paid by a Member before we begin to provide benefits for Covered Services for that Member.
**Family Deductible:** The family Deductible is the maximum deductible amount, listed in your Benefit Summary that a family of three or more Members must pay. All amounts paid by Family Members toward their individual Deductibles apply toward the family Deductible. When the family Deductible is met, no further individual Deductibles will need to be met by any family Members.

*Note:* No Member will ever pay more than an Individual Deductible before we begin paying for Covered Services 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 Providence Health Plan.
- Services in excess of any maximum benefit limit.
- Fees in excess of the usual, customary and reasonable (UCR) charges.
- Copayments or Coinsurance that are specified in the Benefit Summary as not applicable toward the Deductible.

**Deductible Carry Over:** Applicable charges for Covered Services received in the fourth quarter of a calendar year used to meet any portion of the Deductible will be applied toward the next year’s Deductible.

4.9.2 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 Individual Contract.

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

**Family Out-of-Pocket Maximum:** Family Out-of-Pocket Maximum means the total amount of Copayments and Coinsurance that a family must pay in a calendar year, as shown in the Benefit Summary, before we begin to pay 100 percent* for Covered Services for enrolled Family Members. The family Out-of-Pocket Maximum applies when there are more than three Family Members enrolled on this Individual Contract. If three Family Members meet their individual Out-of-Pocket Maximum, the family Out-of-Pocket Maximum will met and no further individual Out-of-Pocket Maximum will need to be met by any other Family Members. If the combined Copayment and Coinsurance expenses of four or more 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 Individual Contract;
- Services not covered because Prior Authorization was not obtained, as required in section 4.5;
- Services in excess of any maximum benefit limit;
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges;
- Copayments or Coinsurance for a Covered Service if indicated in the Benefit Summary as not applicable* to the Out-of-Pocket Maximum;
• Durable Medical Equipment (DME);
• Medical Supplies and Devices; and
• Deductibles.

* Covered Services that are indicated in the Benefit Summary as not applicable to the Out-of-Pocket Maximum are NOT eligible for 100% benefits. The Copayment or Coinsurance for those Services that is shown in the Benefit Summary remains in effect throughout the calendar year.

**4.10 EXCLUSION PERIODS**

An Exclusion Period is the period of time during which specified treatments and Services are excluded from coverage. No benefits for the specified treatments and Services will be payable during the Exclusion Period under this Individual Contract unless:

1. The Member has been continuously covered under this Individual Contract since birth or placement for adoption; or
2. The Member has applicable Creditable Coverage. We will reduce the duration of the Exclusion Period by the amount of the Member's prior Creditable Coverage if the most recent period of Creditable Coverage ended within 63 days of the Effective Date of Coverage under this Individual Contract. However, Creditable Coverage will only be applied to Covered Services that were specified as covered under the prior Creditable Coverage, regardless of the level of such prior coverage or the Member’s use of such prior coverage. The Member is responsible for furnishing proof of Creditable Coverage and evidence of the terms of benefits under the previous coverage.

An Exclusion Period applies to the following treatments and Services under this Individual Contract:

• Elective Procedures – An Exclusion Period of 12 months. Please see Definitions, section 12.
• Organ transplants – An Exclusion Period of 24 months. Please see section 6.1.

**4.11 PRE-EXISTING CONDITIONS**

A Pre-existing Condition means any medical condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the Effective Date of Coverage of the Member. The limitations for a Pre-existing Condition, however, under this Individual Contract do not apply to:

• Genetic information in the absence of a diagnosis of the condition related to such information;
• Services provided to a newly born or adopted child who obtains coverage under this Individual Contract as described in section 3.3; and
• Members under the age of 19.

Coverage for Pre-existing Conditions is excluded under this Individual Contract for a period of six months following the Member’s Effective Date of Coverage.

The period of coverage exclusion, however, will be reduced by the amount of your prior Creditable Coverage if:

1. Your Creditable Coverage is still in effect on your Effective Date of Coverage under this Individual Contract; or
2. Your Creditable Coverage ended no more than 63 days before your Effective Date of Coverage under this Individual Contract.
5. COVERED SERVICES

This section describes Medically Necessary Services that are covered under this Individual Contract, as specified in the Benefit Summary.

Benefits for the treatment of illness or injury, when such treatment is provided by a Qualified Practitioner and Medically Necessary, include the Covered Services that are listed in this section, section 6 and shown in the Benefit Summary.

Benefit Limitations

- For members age 19 and older, most Covered Services are subject to a Pre-existing Condition Exclusion Period, as stated in section 4.11.
- Some Covered Services are subject to one or more of the following limitations:
  - Prior Authorization;
  - Exclusion Periods;
  - Dollar limits;
  - Visit/treatment limits; and
  - In-Plan benefits only.
- All benefit-specific limitations and Exclusion Periods are described in sections 4, 5, 6 and 7 and the Benefit Summary. If you have any questions about these limitations or whether or not a specific benefit is subject to any limitations, please contact your Customer Service representative.

5.1 PROVIDER SERVICES

The following are Covered Services.

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

Office visits, inpatient and outpatient Hospital visits and home visits with a 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 Individual Contract contains a separate and specific Copayment or Coinsurance amount; or (c) are ancillary to the visit and are billed separately by the Qualified Practitioner.

5.1.2 E-visits

Out-of-Plan benefits do NOT apply to E-visits.

E-visits (provider consultation through e-mail) are available from a limited number of Participating Providers and are covered in full.

This benefit allows you to take advantage of the conveniences of e-mail when receiving health care services from a Participating Provider who has agreed to provide this benefit for Providence Health Plan. We will provide benefits for Medically Necessary E-visits provided by a designated Participating Provider for the treatment of a covered illness or injury.
Not all Participating Providers offer E-visits. Medical doctors (MD), Doctors of Osteopathy (DO), Nurse Practitioners (NP) and Physician Assistants (PA) are the only categories of providers approved for E-visits. Please check with your Participating Provider’s office or consult our online provider directory at www.ProvidenceHealthPlan.com to see if your provider offers the E-visit benefit.

Participating 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 Participating 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 Participating 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 communications that do not qualify as E-visits 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 Alcoholism Treatment Services as stated in sections 6.3 and 6.4.

5.1.3 Telemedical Services

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

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

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

5.2 **PREVENTIVE SERVICES**

Preventive Services are covered as shown in the Benefit Summary.

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

- Services rated “A” or “B” by the US preventive Services Task Force, [http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm](http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm);
- 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/](http://www.hrsa.gov/womensguidelines/).

Note: Additional plan provisions apply to some Services (e.g.: routine physical examinations and well-baby care must be received from a Participating Personal Physician/Provider, see section 5.2.1). If you need assistance understanding coverage for Preventive Services under your Plan, please contact Customer Service at 503-574-7500.

5.2.1 Physical Examinations and Well-Baby Care

Benefits for physical examinations and well-baby care for prevention and detection of disease must be received from your Personal Physician/Provider and are provided in accordance with the following schedule, or as recommended by your Personal Physician/Provider. In order for a child to be eligible for benefits for routine newborn baby care, the child must be properly enrolled as outlined in section 3. Ancillary Services, such as immunizations, are covered at the specified benefit levels when billed separately by the provider.

**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.

5.2.2 Immunizations and Vaccinations

Benefits for immunizations and vaccinations are provided in accordance with accepted medical practice and as shown in the Benefit Summary. Visits to your Qualified Practitioner’s office or participating pharmacy for immunizations or injections are subject to the Copayment or Coinsurance shown in the Benefit Summary. Covered Services do not include immunizations or vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel.
5.2.3 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. Benefits also include follow-up exams for any medical conditions discovered during an annual gynecological exam that require additional treatment.

5.2.4 Mammograms

Mammograms are provided for women over 40 years of age 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.

5.2.5 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 Norplant; and
- Oral contraceptives (birth control pills).

All covered services must be received from Qualified Practitioners and Facilities or purchased from Participating Pharmacies.

- **In-plan:** Services are covered in full.
- **Out-of-plan:** Services are covered subject to the provisions of your medical supply benefit, see section 6.2.1.

5.2.6 Women’s Elective Sterilization

Coverage is provided for women’s voluntary sterilization (tubal ligation).

All Covered Services must be received from Qualified Practitioners and Facilities.

- **In-Plan:** Services are covered in full.
- **Out-of-Plan:** Services are covered subject to the provisions of your Outpatient Surgery benefit, as shown in your Benefit Summary.

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.

5.2.7 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.

5.2.8 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:
- **In-Plan:** All Services for colorectal cancer screenings and exams are covered in full.
- **Out-of-Plan:** All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery Benefit. Fecal occult blood test and double contrast barium enemas are covered under the Lab Services benefit.

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

### 5.2.9 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 by a Qualified Practitioner (dental visits are not covered), foot inspection, and influenza vaccine every calendar year; and
- A pneumococcal vaccine every five years.

### 5.3 HOSPITAL AND SKILLED NURSING FACILITY SERVICES

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

Covered Services do NOT include care received that consists primarily of:
- 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.

### 5.3.1 Hospital Services

Benefits are provided as shown in the Benefit Summary and include Services for semiprivate room accommodations, coronary care and intensive care. Other Hospital Covered Services include, but are not limited to, use of the operating room, anesthesia, dressings, medications, whole blood and blood products, oxygen, x-rays, and laboratory Services during the period of inpatient hospitalization.
5.3.2 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 the Benefit Summary.**

5.3.3 Inpatient Rehabilitation Services

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

5.3.4 Observation Care

Benefits are provided, as shown in the Benefit Summary, for Covered Services provided by the Hospital or the Qualified Practitioner while you are held in the Hospital for observation. Covered observation care Services include 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 hours, although in some circumstances, you may require a second day. Observation care for greater than 48 hours without inpatient admission is generally considered not Medically Necessary and may be subject to medical review.

5.4 OUTPATIENT HOSPITAL SERVICES, CHEMOTHERAPY AND RADIATION THERAPY

Benefits are provided as shown in the Other Covered Services section of the Benefit Summary and include outpatient Services at a Hospital or Outpatient Surgical Facility, dialysis, chemotherapy and radiation therapy. See sections 5.7.2 and 5.8 regarding injectable medications. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation and regularly scheduled therapy such as dialysis, chemotherapy, inhalation therapy, or radiation therapy as ordered by your Qualified Practitioner.

We may require that you obtain a second opinion for some Elective Procedures. If you do not obtain a second opinion when requested, we will not give Prior Authorization to the Services.

Covered Services under these benefits do not include Services for Short Term Outpatient Rehabilitation. Please refer to those specific Services within section 5.7.11.

5.4.1 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 participating retail or specialty pharmacy as shown on the Benefit Summary.

When it results in a lower out-of-pocket expense to the Member, self-administered chemotherapy agents will be covered under your outpatient pharmacy benefit as shown on the Benefit Summary.
5.5 **EMERGENCY CARE SERVICES**

Benefits are provided on a worldwide basis for Emergency Medical Conditions, as specified in your Benefit Summary. An Emergency Medical Condition is a condition that manifests itself by 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 place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy. Some examples are:

- 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

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.

Emergency room Services are covered when your medical condition meets the guidelines for emergency care as stated in this section. Covered Services do not include Services for the inappropriate (non-emergency) use of an emergency room. This means Services which could be delayed until you can be seen in a Qualified Practitioner’s office, for example: treatment of minor illnesses such as flu or sore throat, check-ups, follow-up visits and prescription drug requests.

5.5.1 Emergency Care

We will provide coverage for Emergency Medical Screening Exams and stabilization of an Emergency Medical Condition both in and out of the Service Area without Prior Authorization. Hospitalization for an Emergency Medical Condition requires notification to us within 48 hours, or as soon as reasonably possible following the onset of treatment, in order for coverage to continue.

Covered Services do NOT include Services for the inappropriate (non-emergency) use of an emergency room. This means Services which could be delayed until you can be seen in your Qualified Practitioner’s office, for example: treatment of minor illnesses such as flu or sore throat, check-ups, follow-up visits and prescription drug requests.

5.5.2 Emergency Medical Transportation

Benefits include Services for emergency medical transportation by state certified ambulance and certified air ambulance transportation. Out-of-area ambulance Services are provided for transportation to the nearest facility capable of providing the necessary care or to a facility specified by us. Benefits are subject to the dollar limit stated in the Benefit Summary.

5.5.3 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.

5.6 **URGENT/IMMEDIATE CARE SERVICES**

Benefits include Services from an Urgent/Immediate Care facility or other provider and are provided as shown in the Benefit Summary. You are responsible for the urgent care Copayment/Coinsurance, as shown in the Benefit Summary, whenever you receive Urgent/Immediate Care Services. Please be prepared to pay the Copayment/Coinsurance at the time you receive care. You are also responsible for the applicable...
Copayment/Coinsurance shown in the Benefit Summary for any ancillary Services received, such as lab tests, that are billed separately by the Qualified Provider. Urgent/Immediate Care does not include the care of an Emergency Medical Condition.

Urgent/Immediate Care Services provided both in and out of the Service Area are covered for non-life threatening conditions that require immediate attention such as ear, nose and throat infections, and minor sprains and lacerations. Continuing or follow-up care at the Urgent/Immediate Care facility is NOT a Covered Service.

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

5.7 **OTHER COVERED SERVICES**

The following are other Covered Services and are provided as shown in the Benefit Summary.

5.7.1 **Maternity Services**

Benefits include prenatal care, delivery and postnatal care. In accordance with federal and state requirements, coverage of inpatient delivery Services will not be less than 48 hours for normal vaginal deliveries and 96 hours for cesarean section deliveries, unless the mother and treating physician determine that an earlier discharge is appropriate. 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. See section 5.7.5 regarding diagnostic x-ray and laboratory tests, which are covered separately from the global professional fee for maternity Services.

Newborn Nursery Care is a facility Service covered under your Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in your Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under your Provider Inpatient hospital visit benefit.

5.7.2 **Allergy Shots, Allergy Serums and Injectable Medications**

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

Therapy and testing for treatment of allergies including, but not limited to, Services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment are covered only when such therapy or testing is approved by The American Academy of Allergy and Immunology, or The Department of Health and Human Services or any of its offices or agencies.
5.7.3 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.

5.7.4 Diabetes Self-Management Education Program

Benefits are paid in full for initial self-management education programs. You must be enrolled under this Individual Contract throughout the course of the program for benefits to be paid.

5.7.5 Diagnostic Pathology Radiology Tests and Diagnostic Procedures

Benefits are as shown in the Benefit Summary and include inpatient and outpatient diagnostic pathology (lab), imaging (such as PET, CT, MRI), radiology (x-ray) tests and other Medically Necessary diagnostic procedures. Covered Services include contrast materials (dyes) that may be required for a diagnostic procedure.

5.7.6 Home Health Care

Benefits for home health care Covered Services are shown in the Benefit Summary and are as stated in this section. 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 Individual Contract. **Benefits are subject to the durational limits stated in the Benefit Summary.**

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

Home health care will not be reimbursed unless your 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 Individual 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.

5.7.7 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;
- 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.

Extended respite care and other Services not listed in this section are excluded from coverage.

5.7.8 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 6.2.1.

5.7.9 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 6.2 for Medical Supplies/Devices. Covered Services do not include routine foot care and the removal of corns or calluses, unless you have diabetes.

5.7.10 Reconstructive Surgery of the Breast

Benefits for Reconstructive Surgery of the breast are subject to the same Deductibles and Coinsurances applicable to other medical and surgical benefits covered under this Individual Contract and are as stated in the Benefit Summary. Reconstructive Surgery of the breast is covered for:

- Reconstruction of the involved breast following a mastectomy;
- Surgery and construction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.
5.7.11 **Short-Term Outpatient Rehabilitation**

Benefits are included for short-term outpatient physical, occupational and speech therapy Covered Services as stated in the Benefit Summary to restore or improve lost function following illness or injury. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition. 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). **Benefits are subject to the durational limits specified in the Benefit Summary.**

Covered Services under this benefit do **NOT** include:

1. Exercise programs;
2. Rolfing, polarity therapy and similar therapies;
3. Growth and cognitive therapies, including sensory integration; and
4. Rehabilitation Services provided under an authorized home health care plan as stated in section 5.7.6.

5.7.12 **Accidental Injuries**

The Deductible does not apply to Covered Services required to treat an accidental injury within 90 days following the injury. For the purposes of this provision, an accidental injury means an injury that is due directly to an unintentional act, independent of all other causes.

5.8 **PRESCRIPTION DRUG**

**Using Your Prescription Drug Benefit**

- Your prescription drug benefit requires you to have your prescriptions filled at pharmacies that participate with Providence Health Plan. We have approximately 22,000 participating pharmacies available for your use nationwide. A list of our participating pharmacies, including preferred retail pharmacies and participating mail order pharmacies, is available on our website at [www.ProvidenceHealthPlan.com](http://www.ProvidenceHealthPlan.com). You also may contact your Customer Service representative at the telephone number listed on your Member ID card if you need help locating a participating pharmacy in your area or when you are away from your home.

- All Covered Services are subject to the Deductible, Coinsurance, limitations, exclusions and benefit maximums listed in this section and in the Benefit Summary.

- You must present your current Providence Health Plan Member ID card and pay your Coinsurance at the time of purchase. After your Deductible has been met, participating pharmacies may not charge you more than your Coinsurance for covered prescriptions. Please contact your Customer Service representative if you or your pharmacy have questions or need assistance with the processing of your prescription.

- You may purchase up to a 90 day supply of each maintenance drug at one time using a participating mail service pharmacy, as described in section 5.8.1, or at preferred retail pharmacies. The dispensing limits in section 5.8.4 (1) also apply to mail order purchases. Not all prescription drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.

- Insulin is covered. Once you have received insulin for the first time with a prescription, you will not need another prescription to obtain insulin thereafter.

- Diabetes supplies and inhalation extender devices may be obtained at your participating pharmacy. However, these items are considered medical supplies and devices and are subject to your medical supplies and devices benefits, limitations and Coinsurance.
• Self-administered chemotherapy drugs are covered under section 5.4.1 unless the benefits under this section allow for lower out of pocket costs to you, in which case, your prescription drug benefit will apply.
• Some prescription drugs require Prior Authorization in order to be covered as listed in our Prescription Drug Formulary.

5.8.1 Ordering Prescriptions by Mail

To order prescriptions by mail, your physician or provider may call in the prescription or you may mail your prescription along with your Member ID number to one of our participating mail order pharmacies. Participating mail order pharmacy information is available on our website at www.ProvidenceHealthPlan.com. If you do not have access to our website, please call your Customer Service representative for a printed listing of our participating mail order pharmacies.

We recommend that you order refills approximately two weeks before you expect to run out of your current supply of medication. Payment is required prior to processing your order. If there is a change in our participating mail service pharmacies, you will be notified of the change at least 30 days in advance.

5.8.2 Use of Non-Participating Pharmacies

Urgent or emergency medical situations may require that you use a Non-Participating Pharmacy. If this occurs, you will need to pay full price for your prescription at the time of purchase. To request reimbursement, you will need to fill out and submit to us a Prescription Drug Reimbursement form, which can be obtained from our website or by contacting your Customer Service representative and requesting one. You must include all itemized pharmacy receipts along with this form. You will also need to provide explanation as to why you used a non-participating pharmacy. Submission of a claim does not guarantee payment. Reimbursement is subject to your Plan’s limitations and exclusions. If your claim is approved, we will reimburse you the cost of your prescription up to our participating pharmacy contracted rates, subject to plan benefits and limitations, less your applicable Copayment or Coinsurance. You are responsible for any amounts above our contracted participating pharmacy rates.

5.8.3 Prescription Drug Formulary

The Providence Formulary is a list of Food and Drug Administration (FDA) approved prescription brand name and generic drugs developed by physicians and pharmacists. It is designed to offer drug treatment choices for covered medical conditions. The Formulary can help you and your 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.

All drugs must be FDA approved, Medically Necessary and require, by law, a prescription to dispense. Not all FDA approved drugs are covered by us.

Newly approved drugs will be reviewed for safety and Medical Necessity within 12 months follow FDA approval.

Our formulary is updated regularly throughout the year and qualified practitioners are encouraged to submit suggestions for additions to us.

Specialty medications and medications requiring Prior Authorization are listed in our formulary. If you want more detailed information about our drug formulary or drug coverage, including information on drugs requiring Prior Authorization, please visit our website at www.ProvidenceHealthPlan.com, or call your Customer Service representative.
5.8.4 Prescription Drug Limitations

1. Prescription dispensing limits: 1) topicals, up to 60 grams; 2) liquids, up to eight ounces; 3) tablets or capsules, up to 100 dosage units; and 4) multi-use or unit-of-use, up to one container or package; as prescribed, not to exceed a 30 consecutive day supply, whichever is less. Other dispensing limits may apply to certain medications requiring limited use, as determined by us. Prior Authorization is required for amounts exceeding any applicable medication dispensing limits.

2. Certain drugs require Prior Authorization for medical necessity, 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, then Prior Authorization is required. For some drugs, we limit the amount of the drug we will cover. Please have your provider contact us directly for Prior Authorization. If you have questions regarding a specific drug, please call your Customer Service representative at the number listed on your Member ID Card.

3. Specialty drugs are injectable, infused, oral or inhaled therapies that often require specialized delivery, handling, monitoring and administration and are generally high cost. These drugs must be purchased through our designated specialty pharmacy. Due to the nature of these medications, they are not considered maintenance drugs and are limited to a 30 day supply (or minimum package size to approximate a 30 day supply). Specialty drugs are indicated on our formulary as “Specialty” in the status column. To view the formulary, visit our website at www.ProvidenceHealthPlan.com, or contact your Customer Service representative.

4. Self-injectable medications are covered if they are intended for self-administration, and are labeled by the FDA for self-administration.

5. Drugs or hormones to stimulate growth are covered only if there is a laboratory-confirmed diagnosis of growth hormone deficiency. These drugs are covered only for children under age 18, and for adults only if there is documented pituitary destruction and the drug use meets our medical policy criteria.

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 participating pharmacy. Compounded drugs from bulk powders that are not a component of an FDA approved drug are not covered.

5.8.5 Prescription Drug Exclusions

In addition to the Services not listed as covered in section 7, the following are specifically excluded from coverage under this Individual Contract.

1. Drugs used in the treatment of fungal nail conditions.

2. Drugs used in the treatment of the common cold.

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

4. Intrauterine devices (IUDs), diaphragms and implantable contraceptives, except as covered under sections 5.2.5 and 6.2.

5. Drugs or medications delivered, injected or administered to you by a physician or other provider or another trained person.

6. Drugs prescribed by naturopathic physicians (N.D.).

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

8. Drugs used to treat all sexual dysfunctions or disorders, in either men or women, such as Viagra or drugs required for, or as a result of, sexual transformation.
10. Fluoride, for members over the age of 10 years old.
11. Replacement of lost or stolen medications.
12. Drugs used for weight loss or cosmetic purposes.
13. Medications prescribed that do not relate directly to the treatment of a covered illness or injury.
14. Over-the-Counter (OTC) drugs, medications, or vitamins that may be purchased without a provider’s written prescription and prescription drugs that are available in an OTC therapeutically similar form.
15. Devices, appliances, supplies and durable medical equipment, even if a prescription is required for purchase. These items may be covered under your medical benefits. (See section 6.2 for Covered Services for these items).
16. Smoking cessation drug therapy, including nicotine replacement therapy, except as provided in section 6.7.
17. Drugs dispensed from pharmacies outside the United States, except for Urgent and Emergency Medical Conditions.
18. Drugs or prescribed medications that are not Medically Necessary or are not provided according to our medical policy.
19. Drugs to stimulate hair growth, including, but not limited to, Rogaine (i.e., topical minoxidil) or other similar drug preparations.
20. Drugs used in the treatment of drug induced fatigue, general fatigue and idiopathic hypersomnia.
21. Drugs that are not FDA approved or are designated as “less than effective” by the FDA (also known as a “DESI” drug).
22. Drugs placed on prescription-only status as required by state or local law.
23. Methadone for the treatment of chemical dependency. However, methadone for pain management is covered.
24. Drugs prescribed or recommended by chiropractic physicians.
25. Injectable medications, except as stated in sections 5.7.2 and 5.8.4.
26. Any drug, medicine, or device that does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Pre-market Approval, or 510K.
27. Vaccines, immunizations and preventive medications solely for the purpose of travel.

5.8.6 Prescription Drug Disclaimer
We are 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 Individual Contract.
6. LIMITED COVERED SERVICES

6.1 HUMAN ORGAN/TISSUE TRANSPLANTS

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

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

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

6.1.1 Covered Services

(See also the Exclusion Period in section 4.10.)

Covered Services for transplants are limited to Services that:

- Are determined by us to be Medically Necessary and medically appropriate according to national standards of care;
- Are provided at a facility approved by us or under contract with us (Out-of-Plan benefits do NOT apply to transplant Services);
- Involve one or more of the following organs or tissues:
  - Heart
  - Lung
  - Liver
  - Kidney
  - Pancreas
  - Small bowel
  - Autologous hematopoietic stem cell/bone marrow
  - Allogeneic hematopoietic stem cell/bone marrow; and
- Are directly related to the transplant procedure, including Services that occur before, during and after the transplant procedure.

Covered Services for transplant recipients include medical Services, Hospital Services, medical supplies, medications and prescription drugs while hospitalized, diagnostic modalities, prosthesis, high dosage chemotherapy for stem cell/bone marrow transplants, and travel expenses. 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:

- Initial evaluation of the donor and related program administration costs;
- Preserving the organ or tissue;
- Transporting the organ or tissue to the transplant site;
- Acquisition charges for cadaver or live donor;
- Services required to remove the organ or tissue from the donor; and
- Treatment of medical complications directly resulting from the surgery performed to obtain the organ or tissue for a period of time not to exceed 30 consecutive days following that surgery.
6.1.2 Benefits for Transplant Facility Services Provided to the Organ Recipient

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

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

6.1.3 Benefits for Outpatient Medications

Outpatient prescription medications, including anti-rejection (immunosuppressive) drugs, are covered under the prescription portion of this Individual Contract.

6.1.4 Benefits for Physician/Provider Services Provided to the Organ Recipient

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

6.1.5 Prior Authorization

(See also section 4.5.)

To qualify for coverage under this Individual 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.

6.1.6 Exclusion Period and Creditable Coverage

No benefits for human organ/tissue transplant Covered Services will be payable during the first 24 months that a Member is covered under this Individual Contract. See section 4.11 regarding Creditable Coverage.

6.1.7 Transplant Exclusions

In addition to the exclusions listed in section 7 of this Individual Contract, 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, 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 Individual Contract; and
- Transplant-related travel expenses for the donor and the donor's and recipient’s family members.
6.2 **MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT (DME), APPLIANCES, PROSTHETIC AND ORTHOTIC DEVICES, AND HEARING AIDS**

Benefits for medical supplies, Durable Medical Equipment (DME), appliances, prosthetic and orthotic devices, and hearing aids are provided when required for the standard treatment of illness or injury.

**Coverage of DME and appliances is limited to $2,500 per member per calendar year.** (This $2,500 limit does not apply to medical supplies (including diabetes supplies), prosthetic and orthotic devices, or hearing aids).

We may authorize the purchase of an item if we determine the cost of purchasing an item would be less than the overall rental of the item. Services must be prescribed by your 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.

6.2.1 **Medical Supplies (Including Diabetes Supplies)**

Benefits are shown in the Benefit Summary for the following medical 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 may be purchased through Providence Health Plan medical supply providers or under your Prescription Drug Benefit at participating pharmacies. Diabetes test strips are limited to 100 per month for insulin dependent Members and 100 every three months for non-insulin dependent Members, unless otherwise prescribed by your Qualified Practitioner.

3. Removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotics do not include prosthetic devices or childhood braces. **Removable custom orthotic shoe inserts are subject to the dollar limit stated in the Benefit Summary.**

4. Medically Necessary medical foods for supplementation or dietary replacement including non-prescription elemental enteral formula for home use, when determined to be Medically Necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition. Medical foods are also covered for the treatment of Inborn Errors of Metabolism, as described in section 5.7.8. Medical foods do not include total parenteral nutrition (TPN), which is covered under section 5.7.2.

6.2.2 **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).
6.2.3 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. Medical devices that are surgically implanted into the body to replace or aid function. If you receive a procedure to implant a medical device, you will be responsible for any Copayment or Coinsurance for the medical device in addition to any Copayment or Coinsurance for the procedure.

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

6.2.4 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 6.2.1)

6.2.5 Hearing Aids for Dependent Children

Medically Necessary external hearing aids and devices, one per ear, prescribed by a licensed audiologist and received from an approved provider are covered for Members 18 years of age and younger, and Members 19 through 25 years of age if enrolled in secondary school or an accredited educational institution. “Hearing aids and devices” are defined as any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries and cords. Coverage is provided under your Medical Supplies benefit, as shown on your Benefit Summary, and is limited to $4,000 every four years. This limit will be adjusted January 1st of each calendar year to reflect the U.S. City Average Consumer Price Index.

6.3 OUTPATIENT MENTAL HEALTH SERVICES

Benefits are provided for mental or nervous conditions based on criteria established by the ICD-9 and DSM-IV manuals. A copy of those criteria can be obtained by calling your Customer Service representative at the number on your Member ID Card.

To obtain Mental Health Services, contact Providence Health Plan’s authorizing agent at 1-800-711-4577. The authorizing agent and your Qualified Practitioner will coordinate your care.

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. Your Individual Contract does not include coverage for Mental Health inpatient services.

Covered Services include outpatient diagnostic evaluation, and outpatient, individual and group therapy.
Covered Services must be:

- Part of an approved treatment program; and
- Prior Authorized by our authorizing agent. Our authorizing agent and your Qualified Practitioner will work together to coordinate your care.

Benefits are subject to the visit limit stated in the Benefit Summary.

6.4 **ALCOHOLISM TREATMENT SERVICES**

Benefits for alcoholism treatment Services include inpatient detoxification, outpatient diagnostic evaluation, and outpatient individual and group therapy. **Benefits are subject to the visit and durational limit stated in the Benefit Summary.**

To obtain alcoholism treatment Services, contact our authorizing agent at 1-800-711-4577. The authorizing agent and your Qualified Practitioner will coordinate your care.

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.

6.4.1 The 24-Month Benefit Period

The 24-month benefit period for alcoholism treatment Services renews on January 1 of all odd-numbered years.

6.4.2 Combined Mental Health and Alcoholism Treatment Services

In instances where Members need to access both Mental Health and alcoholism treatment Services, Covered Services for Mental Health will be applied to Mental Health benefit limits and Covered Services for alcoholism treatment will be applied to the alcoholism treatment benefit limits, up to the visit and durational limits for each category of Services as stated in the Benefit Summary.

6.5 **OUTPATIENT HOSPITALIZATION AND ANESTHESIA FOR DENTAL SERVICES**

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

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

Dental Services are excluded.

6.6 **TOBACCO USE CESSATION SERVICES**

Coverage is provided for Members 15 years of age and older for participation in a PHP-approved, physician-recommended tobacco use cessation program that follows the United States Public Health Service guidelines. “Tobacco use cessation program” includes educational and medical treatment components, such as but not limited to counseling, classes, nicotine replacement therapy and prescription drugs designed to assist Members in ceasing the use of tobacco products. A list of PHP-approved programs is available online at www.ProvidenceHealthPlan.com and by calling Customer Service at 503-574-7500 or 1-800-878-4445.
6.7 **GENETIC TESTING AND COUNSELING SERVICES**

Genetic studies and counseling require Prior Authorization and 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.

6.8 **ROUTINE VISION**

Benefits for routine vision Services are covered as shown in the Benefit Summary. Dollar amount and frequency limitations apply. To find a VSP Select Participating Provider, go to [www.vsp.com/select](http://www.vsp.com/select).

You will be responsible for the cost of any Services that exceed the limits shown in the Benefit Summary.

Coverage is provided for eye examinations, frames and basic lenses for single, bifocal, and trifocal prescriptions. Lens options that enhance the comfort and function of prescription glasses may be covered upon approval. Lens options include:

- Higher power
- Prism
- Slab off
- Lenticular or variable asphericity lenses.

Coverage of contact lenses is also provided in lieu of a complete pair of glasses.

Vision benefits do not apply to your Deductible or Out-of-Pocket Maximum.

Benefit administration of routine vision services is provided by our authorized representative, Vision Services Plan (VSP). To contact VSP member services, visit their website at [www.vsp.com](http://www.vsp.com) or call 1-800-877-7195.
7. EXCLUSIONS

In addition to those Services listed as not covered in sections 5 and 6, the following are specifically excluded from coverage under this Individual 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 5.5;
- 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;
- Are self-administered or provided by a person who ordinarily resides in your home or who is a member of your immediate family (parent, spouse, sibling or child);
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos and books, educational programs to which drivers are referred by the judicial system and volunteer mutual support groups;
- Are 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 Individual 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. Any benefits or Services provided under this Individual 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 8.3. This exclusion also applies to Services and supplies after you have received proceeds from a settlement as specified in section 8.3.3;
- Are provided in an institution that specializes in treatment of developmental disabilities;
• Are provided for treatment or testing required by a third party or court of law which is not Medically Necessary;
• Are Experimental/Investigational;
• Have not been Prior Authorized as required in this Individual Contract;
• 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;
• 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 6.1;
• Services for Durable Medical Equipment (DME), Medical Supplies/Devices and Prosthetic Devices except as described in section 5.7.9;
• 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 and rehabilitation Services, except as provided in sections 5.3.3 and 5.7.11;
• “Telephone visits” by a physician or “environment intervention” or “consultation” by telephone for which a charge is made to the patient. “Get acquainted” visits without physical assessment or diagnostic or therapeutic intervention provided and treatment sessions by computer Internet service;
• Missed appointments;
• Non-emergency medical transportation;
• Allergy shots and allergy serums, except as provided in section 5.7.2;
• All Services and supplies related to the treatment of obesity or morbid obesity;
• Services for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas;
• Transportation or travel time, food, lodging accommodations and communication expenses except as provided in section 6.1.1 and with our prior approval;
• Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
• Massage therapy;
• Light therapy for seasonal affective disorder, including equipment;
• Any vitamins, dietary supplements, and other non-prescription supplements;
• Services for genetic testing are excluded, except as provided in Section 6.7. 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 6.7 or when provided as Extra Values or Discounts (see our website, www.ProvidenceHealthPlan.com), where available;
• Services for Cosmetic Services including supplies and drugs, except as approved by us and described in sections 5.7.3 and 5.7.10;
• Services, including routine physical examination, immunizations and vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel;
• Non-sterile examination gloves;
• Sales taxes, handling fees and similar surcharges, as explained in the definition of UCR; and
• Air ambulance transportation for non-emergency situations unless approved by us in advance.

Exclusions that apply to Mental Health and Alcoholism Treatment Services:
• Conditions for mental and nervous conditions not specified in the current edition of the DSM-IV;
• Services provided under a court order or as a condition of parole or probation or instead of incarceration which are not Medically Necessary;
• Personal growth Services such as assertiveness training or consciousness raising;
• Services related to developmental disabilities, developmental delays or learning disabilities including, but not limited to, education Services. A learning disability is a condition where there is meaningful difference between a child’s current academic function and the level expected for a child that age. Educational Services include, but are not limited to, language and speech training, reading, and psychological and visual integration training as defined by the American Academy of Pediatrics Policy Statement—“Learning Disabilities, Dyslexia and Vision: A Subject Review;”
• School counseling and support Services, home-based behavioral management, household management training, peer support Services, recreation, tutor and mentor Services; independent living Services, therapeutic foster care, wraparound Services; emergency aid 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 mental retardation and motor skill disorders, and educational speech delay including delayed language development (except as provided in sections 5.3.3. and 5.7.11);
• Counseling related to family, marriage, sex and career including, but not limited to, counseling for adoption, custody, family planning or pregnancy, in the absence of a DSM-IV-TR diagnosis;
• Neurological Services and tests including, but not limited to EEGs; PET, CT and MRI imaging Services; and beam scans (except as provided in section 5.7.5);
• Services related to the treatment of sexual disorders, dysfunctions or addiction;
• Vocational, pastoral or spiritual counseling;
• Dance, poetry, music or art therapy, except as part of an approved treatment program;
• Treatments that do not meet the national standards for Mental Health and Alcoholism Treatment professional practice;
• Services described in section 6.3 are excluded for the treatment of autism and Asperger’s syndrome; and
• Services for the treatment of chemical dependency, except as provided for the treatment of alcoholism as stated in section 6.4; and
• All inpatient, day or partial day, and residential services, except for alcoholism detoxification services as stated in your Benefit Summary.

**Exclusions that apply to Provider Services:**
- The following Services if provided, ordered or approved by Non-Participating Providers: human organ/tissue transplants, chiropractic care, E-visits, and outpatient prescription drug;
- Services of licensed acupuncturists, a physician performing acupuncture Services, naturopathic physicians, chiropractic physicians and licensed massage therapists; and
- Services of homeopaths; faith healers; or lay, Direct Entry or Certified Professional midwives.

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

**Exclusions that apply to Vision Services:**
- Surgical procedures which alter the refractive character of the eye, including, but not limited to laser eye surgery, radial keratotomy, myopic keratomelelusis and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia, hyperopia or astigmatism; 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 6.2.5; and
- Hearing screenings and exams.

**Exclusions that apply to Dental Services:**
- Oral surgery (non-dental or dental) or other dental Services (all procedures involving the teeth, wisdom teeth, areas surrounding the teeth, and dental implants), except as stated in section 6.5;
- Services to treat temporomandibular joint syndrome (TMJ); and
- Dentures and orthodontia.

**Exclusions that apply to Foot Care Services:**
- Routine foot care, such as removal of corns and calluses, except for Members with diabetes; and
- Services for insoles, arch supports, heel wedges, lifts and orthopedic shoes, except as described in section 6.2 under Medical Supplies/Devices.
8. CLAIMS ADMINISTRATION

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

8.1 CLAIMS PAYMENT

Our payments for most Services are made directly to the providers of Services. Except as otherwise specifically provided in this Individual Contract, if you are billed directly and pay for benefits which are covered by this Individual 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.

8.1.1 Timely Submission of Claims

We will make no payments for claims received more than 365 days after the date of Service. Exceptions 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 414.725 will be made in accordance with ORS 743.847.

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

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

8.1.2 Right of Recovery

We have the right, upon demand, to recover from a recipient the value of any benefit or claim payment that exceeded the benefits available under this Individual 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.

8.2 NON-DUPLICATION OF COVERAGE

If a Member has any other group or individual coverage (including government-sponsored programs such as Medicare), we will be considered the secondary payer. We will not pay for any Services beyond ensuring total payments from all sources reach the amount we would have paid had we been the only payer.

- If the total reimbursement from other coverage (Amount A) equals or exceeds the benefits payable under this Individual Contract (Amount B), then no additional payment will be made under this Individual Contract. However,
- If Amount A is less than Amount B, then a payment will be made under this Individual Contract for the difference between Amount A and Amount B.
8.2.1 Coordination with Medicare

If you are entitled to Medicare benefits and are covered under this Individual Contract at the same time, Medicare is primary and we are secondary. This means that Medicare pays benefits for Covered Services first and we pay second. Our payments as secondary to Medicare will be calculated to ensure that total payments do not exceed the Medicare allowable amount.

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

8.3 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 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 Individual Contract as specified in section 3.5. In addition, you or the Member must execute and deliver to us and to other parties any document requested by us which may be appropriate to confirm or secure the rights and obligations of the Member and Providence Health Plan under these provisions.

8.3.1 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 Individual 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.

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

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

8.3.3 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 Individual 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 Individual Contract, or under any future Individual or Group Contract 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 Individual Contract, calculated using our providers' usual 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 Individual 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.
9. PROBLEM RESOLUTION

9.1 INFORMAL PROBLEM RESOLUTION

All of the employees of Providence Health Plan share responsibility for assuring Member satisfaction. If you have a problem or concern about your coverage, including benefits or Services by Participating Providers or payment for Services by Non-Participating Providers, please ask for our help. Your Customer Service 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.

9.2 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 purposed of continuity of care.

Authorized Representative

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

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.

9.2.1 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 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 and records held by the Plan that relate to your Grievance or appeal.

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

To the extent possible, complaints filed by telephone will be resolved at the point of Service by your Customer Service representative. All Grievances and appeals (except those involving Prior Authorizations, as discussed below) will be acknowledged within seven days of receipt by us and resolved within 30 days or sooner depending on the clinical urgency. We may request an additional 15 days to resolve the issue if we provide you with a notice of delay, including the reason for the delay, before the 30 day period has elapsed.

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

**Grievances and Appeals Involving Prior Authorizations (Non-Urgent):** If your Grievance or appeal involves a Prior Authorization request for a non-urgent medical condition, we will notify you of our decision, within 30 days of receiving your request for review.

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

9.2.2 Grievance or Appeal

You must file your Grievance or appeal within 180 days of the date on our notice of initial decision, or that initial decision will become final. Please advise us of any additional information that you want considered in the review process. If you are seeing a Non-Participating 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. The Grievance or appeal will be reviewed by Providence Health Plan staff not involved in the initial decision. You may present your case in writing. Once a final determination is made, you will be sent a written explanation of the decision.

9.2.3 External Review

If you are not satisfied with our final determination and your Grievance or appeal involves a denial of services because they are not Medically Necessary, not an active course of treatment for purposes of continuity of care, because they are Experimental/Investigational, or whether a course of treatment is delivered in an appropriate setting at an appropriate level of care, you 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 final determination, 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 Insurance Division 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 Insurance Division 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.

All costs for the handling of external review cases are paid by us and we administer these provisions in accordance with the insurance laws and regulations of the state of Oregon. By electing to submit your appeal to an IRO, you are also agreeing to be bound by and to comply with the IRO decision regarding your appeal in lieu of appealing to a state or federal court. If we do not comply with the IRO decision, we may be penalized by the Department of Consumer and Business Services, and you have the right to sue us under applicable Oregon law.

9.2.4 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.

9.2.5 How to Submit Grievances or Appeals
You may contact Your Customer Service representative at 503-574-7500 or 1-800-878-4445. If you are hearing impaired and use a Teletype (TTY) Device, please call our TTY line at 503-574-8702 or 1-888-244-6642. Written Grievances or Appeals should be sent to:

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

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

Providence Health Plan
3601 SW Murray Blvd
Beaverton, Oregon 97005

9.2.6 Assistance with your Grievance or Appeal
You may, at any time during the appeal and Grievance process, seek assistance from the Oregon Insurance Division with your concerns regarding our decisions and benefits. You may contact the Oregon Insurance Division by calling (503) 947-7984 or by writing to the Oregon Insurance Division, Consumer Protection Unit, 350 Winter ST. NE, Room 440-2, Salem, OR, 97301 or through their website at http://www.cbs.state.or.us/external/ins/.
10. DURATION, REVISION AND RENEWAL OF THE INDIVIDUAL CONTRACT

This Individual Contract is guaranteed renewable and will not be terminated due to claims experience, health status, or length of time in force. Your payment of premium constitutes acceptance of the provisions of this Individual Contract. We may revise this Individual Contract 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.

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

1. When the Policyholder fails to pay the Premium by the due date as specified in section 3.4.3.
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 Dependent spouse or Dependent child enrolled on a Dependent-only Plan ceases to reside in our Oregon Service Area, as stated 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 Health Benefit 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 Health Benefit 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 Health Benefit Plans.
7. When we cease to offer or elect not to renew an Individual Health Benefit 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 Individual Contract within that specified Service Area, we will send written notice to all Policyholders covered by this Individual Contract at least 90 days prior to discontinuation. In addition, we will offer to all affected Policyholders all other Individual Health Benefit 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 Participating Providers, when we no longer have any Members living, residing or working in our Service Area.
10. When we implement a uniform modification of coverage upon renewal for all Policyholders in accordance with standards adopted by the Director, provided that we furnish written notice of the modification to the Policyholder at least 30 days prior to the renewal date.
11. GENERAL PROVISIONS

11.1 AMENDMENT OF PLAN

The provisions of this Individual 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.

11.2 BINDING EFFECT

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

11.3 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 with a current health statement 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.

11.3.1 Combining Coverage Under One Plan

Members who are enrolled under separate Individual 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 Individual 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 Individual 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 with a current health statement 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.

11.4 CIRCUMSTANCES BEYOND THE CONTROL OF PROVIDENCE HEALTH PLAN

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

11.5 **CHOICE OF STATE LAW**

The laws of the State of Oregon govern the interpretation of this Individual Contract and the administration of benefits to Members.

11.6 **DUPLICATING PROVISIONS**

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

11.7 **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 Individual 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 Individual 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 3.5.1.

11.8 **HOLD HARMLESS**

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

11.9 **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 1-503-947-7984 or by writing to:

Oregon Insurance Division,  
Consumer Protection Unit,
11.10 INTEGRATION
This Individual Contract, consisting of this document and the Benefit Summary, embodies the entire Individual Contract of the parties. There are no promises, terms, conditions or obligations other than those contained herein. This Individual Contract shall supersede all other communications, representations or agreements, either verbal or written, between the parties.

11.11 LEGAL ACTION
No legal or equitable action may be brought under state or federal law to recover benefits from this Individual Contract until receipt of a final decision from the Providence Health Plan Grievance Committee or an Independent Review Organization, if applicable. No such action may be brought later than three years after receipt of the final decision.

11.12 MEMBER RESPONSIBILITY
It is your responsibility to read and to understand the terms of this Individual Contract. We will have no liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Individual Contract. If you have any questions or are unclear about any provision concerning this Individual Contract, please contact us. We will assist you in understanding and complying with the terms of this Individual Contract.

11.13 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 Individual Contract.

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

11.15 NONWAIVER
No delay or failure when exercising or enforcing any right under this Individual Contract shall constitute a waiver or relinquishment of that right and no waiver or any default under this Individual Contract shall constitute or operate as a waiver of any subsequent default. No waiver of any provision of this Individual 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.

11.16 NO RECOURSE 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.

11.17 NO REINSTATEMENT BY ACCEPTANCE OF PAYMENT
If this Individual Contract is terminated for any reason, our acceptance of Premium after notice of the termination shall not guarantee a reinstatement of this Individual 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.

11.18 **NOTICE**

Any notice required of us under this Individual 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 www.ProvidenceHealthPlan.com.

11.19 **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 Individual Contract. We also have the right to make an autopsy in case of death if not forbidden by law.

11.20 **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 Plan.

11.21 **PRIVACY OF MEMBER INFORMATION**

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

The following are ways we may use or share information about you:

- We will use the information to administer your 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. For example, if you are in the Hospital, we may give them access to any medical records sent to us by your doctor.
- We may use or share your information with others to help manage your health care. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your health.
- We may share your information with individuals who perform business functions for us. We will only share your information if there is a business need to do so and if our business partner agrees to protect the information.
- 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. For example, we sometimes send out newsletters that let you know about “healthy living” alternatives such as smoking cessation or weight loss programs.

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

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

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

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

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

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

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

11.22 PROFESSIONAL REVIEW AND RIGHT TO EXAMINE RECORDS

All Members, by acceptance of the benefits of this Individual 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 Individual 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.
11.23 PRORATION OF BENEFITS

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

11.24 PROVIDER PAYMENTS

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

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

11.25 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.

11.26 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.

11.27 TERMINATION AND RESCISSION OF COVERAGE DUE TO FRAUD OR ABUSE

Coverage under this Individual 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 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. In addition, we may deny future enrollment to you and to your dependents under any Providence Health Plan for a period of five years from such rescission or termination. We will provide all affected plan participants with 30 days notice before rescinding your coverage.

11.28 WORKERS' COMPENSATION INSURANCE

This Individual 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 Contract and appear throughout as Capitalized text.

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 Individual Contract.

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

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

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 Usual, Customary and Reasonable (UCR) charges for the Covered Service. Your Coinsurance will usually be less when you receive Covered Services from a Participating Provider.

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 the Covered Services section of this Individual Contract;
- Medically Necessary;
- Not listed as an Exclusion in the Benefit Summary or in sections 4, 5, 6 and 7; and
- Provided to you while you are a Member and eligible for the Service under this Individual Contract.

Creditable Coverage
Creditable Coverage means prior health care coverage as defined in 42 U.S.C. § 300gg and includes any coverage remaining in force at the time a Member obtains new coverage. Creditable Coverage includes any group health care coverage (including the Federal Employees Health Benefits Plan and the Peace Corps), individual health care coverage, Medicare, Medicaid, TRICARE, S-CHIP, Indian Health Service or tribal organization coverage, state high-risk pool coverage, or a domestic or foreign public health plan.
**Custodial Care**

Custodial Care means Services that:
- 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**

1. Individual Deductible means the dollar amount, as shown in the Benefit Summary, that a Member is responsible to pay for Covered Services within a calendar year before any benefits are provided by this Individual Contract with respect to that Member. Deductible amounts paid by a Member for Covered Services in the last three months of a calendar year will be carried forward and applied toward the Deductible for the following year.

2. Family Deductible means the maximum Deductible amount, as shown in the Benefit Summary, that a family of three or more Members must pay. All amounts paid toward the Individual Deductible by a Family Member are counted toward the Family Deductible. Once the Family Deductible is met, all Individual Deductibles are satisfied for that calendar year. (Note: No Member will ever pay more than an Individual Deductible before the Contract begins paying for Covered Services for that Member.)

3. The following out-of-pocket costs do NOT apply to the Individual or Family Deductible:
- Services not covered under this Individual Contract;
- Services not covered because Prior Authorization was not obtained, as required in section 4.5;
- Services in excess of any maximum benefit limit;
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges; and
- Copayments or Coinsurance for benefits that are specified in the Benefit Summary as not applicable toward the Deductible.

Deductible amounts are payable after the associated claim has been processed by us.

The dollar amounts you pay for Covered Services received from Participating Providers and Non-Participating Providers apply to the Individual and Family Deductibles.

**Dependent-only Plan**

Dependent-only Plan means an Individual Contract covering only your Eligible Family Dependent age 0-17 years.

**Director**

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

**Domestic Partner**

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

Note: All provisions of this Individual 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 Individual Contract commences for a Member.

**Eligible Family Dependent**
Subject to the enrollment provisions of section 3.2, 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 the Policyholder’s spouse provides at least 50% support;
   - A child placed for adoption with the Policyholder or Policyholder’s spouse;
   - An unmarried child for whom the Policyholder or the Policyholder's spouse is a legal guardian and for whom the Policyholder or the Policyholder's spouse provides at least 50% support; and
   - A child for whom the Policyholder or the Policyholder’s spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law.

Placement for adoption means the assumption and retention by a Policyholder or a Policyholder’s legally recognized spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption). 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 Individual 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 17, and such a Member shall become ineligible for coverage under this Individual Contract on the last day of the month in which their 18th birthday occurs.

Enrolled Eligible Family Dependents who become ineligible for coverage under this Individual Contract may be eligible to continue coverage under a separate Individual Contract as specified in section 3.4.

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.
Within 60 days of the Eligible Family Dependent reaching the limiting age, and upon our request, you must provide satisfactory proof that the above conditions continuously exist on and after the date the limiting age is reached. 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.

**Elective Procedure**
A procedure we determine can be reasonably postponed until the end of the Exclusion Period.

**Emergency Medical Condition**
Emergency Medical Condition means a medical condition that manifests itself by 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
- 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.

**Emergency Medical Screening Exams**
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.

**Emergency Services**
Emergency Services means with respect to an Emergency Medical Condition:
- An emergency medical screening exam 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 42 U.S.C. 1395dd, the Emergency Medical Treatment and Active Labor Act (EMTALA), to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at the Hospital.

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

**Exclusion Period**
Exclusion Period means a period of time during which all specified treatments or Services are excluded from coverage. If treatment was covered under previous plan, then exclusion period is reduced by each day of continuous prior Creditable Coverage.

**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 Individual Contract. A Dependent-only Family Member means an Eligible Family Dependent, of a non-enrolled Policyholder, who is under age 18 when enrollment commences in this Individual Contract.

**Grievance**
See section 9.

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

**Home Health Provider**
Home Health Provider means a public or private agency that specializes in providing skilled nursing Services and other therapeutic Services in the home and which has been licensed by the proper authority as a Home Health Agency, or 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 and Standard Health Statement**
Individual Application and Standard Health Statement means the electronic or paper document created by us and in compliance with ORS 743.766 that must be completed by an individual seeking coverage under this Individual Contract.

**Individual Contract**
Individual Contract means the provisions of this Individual & Family Plan document and the Benefit Summary that accompanies this document.

**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 treating physician 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 the Plan.

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 Individual Contract.

**Mental Health**
Mental Health means conditions meeting the diagnostic criteria defined as mental disorders in the ICD and DSM-IV manuals.

**Non-Participating Provider**
Non-Participating Provider means an Outpatient Surgical Facility, Home Health Provider, Hospital, Qualified Practitioner, Qualified Treatment Facility, or Skilled Nursing Facility 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
Out-of-Pocket Maximum means the calendar-year threshold under which this Individual Contract will begin to pay 100% for Covered Services*, as follows:

1. Individual Out-of-Pocket Maximum means the amount of Coinsurance and Copayment within a calendar year, as shown in the Benefit Summary, that a Member must pay before this Individual Contract will provide 100% benefits* for additional Covered Services within the calendar year.

2. Family Out-of-Pocket Maximum means the combined amount of Coinsurance and Copayment within a calendar year, as shown in the Benefit Summary, that all Family Members must pay before this Individual Contract will provide 100% benefits* for additional Covered Services within the calendar year. The family Out-of-Pocket Maximum will be satisfied if:
   • Three Family Members each meet their individual Out-of-Pocket Maximum, or
   • Four or more Family Members have combined Coinsurance or Copayment expenses that meet the family Out-of-Pocket Maximum amount.

The dollar amounts you pay for Covered Services received from Participating Providers and Non-Participating Providers apply to the Individual and Family Out-of-Pocket Maximums.

The following Member-paid amounts do NOT accumulate toward the Out-of-Pocket Maximum:
   • Services not covered by this Individual Contract;
   • Services not covered because Prior Authorization was not obtained, as required in section 4.5;
   • Services in excess of any maximum benefit limit;
   • Fees in excess of the Usual, Customary and Reasonable (UCR) charges;
   • Copayments or Coinsurance for a Covered Service if indicated in the Benefit Summary as not applicable* to the Out-of-Pocket Maximum;
   • Durable Medical Equipment (DME);
   • Medical Supplies and Devices; and
   • Deductibles.

* Covered Services that are indicated in the Benefit Summary as not applicable to the Out-of-Pocket Maximum are NOT eligible for 100% benefits. The Copayment or Coinsurance for those Services that is shown in the Benefit Summary remains in effect throughout the calendar year.

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 Pharmacy
Participating Pharmacy means a pharmacy that has a signed contract with Providence Health Plan to provide medications and other Services at special rates. There are four types of participating pharmacies:
   1. Retail: a participating pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions.
   2. Preferred Retail: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.
   3. Specialty: a participating pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.
   4. Mail Order: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.
**Participating Provider**
Participating 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 under this Individual Contract.

**Personal Physician/Provider**
Personal Physician/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. Adult female Members also 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 Personal Physician/Provider.

(Note: Not all Qualified Practitioners are Personal Physicians/Providers. To obtain a listing of Participating Personal Physicians/Providers please see the Online Participating Provider Directory or call Your Customer Service representative.)

**Plan Year**
Plan Year means the 14 month period for which Premium rates for this Individual Contract have been approved by the Director.

**Plan Year Aggregate Limit**
Plan Year Aggregate Limit is the maximum amount of Essential Health Benefits payable per Member under this Individual Contract within a Plan Year, as specified in the Benefit Summary.

The term “Essential Health Benefits” has the meaning established under section 1302(b) of the Patient Protection and Affordable Care Act (PPACA) and applicable regulations, and includes at least the following general categories:

- 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 oral and vision care.

**Policyholder**
Policyholder means the person to whom this Individual Contract has been issued. A policyholder shall be age 18 or older. If enrollment under this Individual Contract consists solely of one child who is under age 18, the adult person who applied for such coverage shall be deemed to be the Policyholder until such child reaches the age of 18 when this Individual Contract shall be reissued to show the 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 Individual Contract. Premium rates are subject to change at the beginning of each Plan Year.
Pre-existing Condition
Pre-existing condition means any medical condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the effective date of coverage of the member. The limitations for a pre-existing condition under this Individual Contract do not apply to:
1. Genetic information in the absence of a diagnosis of the condition related to such information;
2. Services provided to a newly born or adopted child who obtains coverage under this plan as described in section 3.3; and
3. Members under the age of 19.

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 Individual Contract. Services that require Prior Authorization are stated in section 4.5.

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

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

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

Qualified Treatment Facility
Qualified Treatment Facility means a facility, institution or clinic duly licensed by the appropriate governmental agency, which is primarily established and operating within the lawful scope of its license.

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.

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
Service Area means the geographic area in Oregon as specified in section 13, within which the Policyholder, the Dependent spouse, or Dependent-only member must physically reside in order to qualify for coverage under this Individual Contract.
**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 or certified as a “Skilled Nursing Facility” by the Secretary of Health and Human Services pursuant to Title XVIII of the Social Security Act.

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

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

When a Service is provided by a Non-Participating Provider, UCR charges will be based on the lesser of:
- The fee a professional provider usually charges for a given Service;
- A fee which falls within the range of usual charges for a given Service billed by most professional providers in the same locality who have similar training and experience;
- A fee which is prevalent or which would not be considered excessive in a particular case because of unusual circumstances; or
- The fee determined by comparing charges for similar Services to a national database adjusted to the geographical area where the Service was performed.

UCR charges do not include sales taxes, handling fees and similar surcharges and such taxes, fees and surcharges are not covered expenses.

**Women's Health Care Provider**
Women’s Health Care Provider means an obstetrician or gynecologist, or physician assistant specializing in women’s health, advanced registered nurse practitioner specialist in women’s health or certified nurse midwife, practicing within the applicable lawful scope of practice.
13. SERVICE AREA

Service Area ZIP Codes

All Policyholders, Dependent spouses and Dependent-only Members must reside in the following Oregon counties or Zip Codes to be eligible for coverage under this Individual Contract. (Please see the Service Area definition in section 12 and section 3 for eligibility information.).

All Zip Codes in the following Oregon counties:

<table>
<thead>
<tr>
<th>County</th>
<th>Zip Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benton</td>
<td></td>
</tr>
<tr>
<td>Clackamas</td>
<td></td>
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<tr>
<td>Clatsop</td>
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<tr>
<td>Columbia</td>
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<tr>
<td>Crook</td>
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<tr>
<td>Deschutes</td>
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<tr>
<td>Douglas</td>
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<tr>
<td>Gilliam</td>
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<tr>
<td>Grant</td>
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<tr>
<td>Harney</td>
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<tr>
<td>Hood River</td>
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<td>Jefferson</td>
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<td>Tillamook</td>
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<td>Wasco</td>
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<td>Washington</td>
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<tr>
<td>Wheeler</td>
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<tr>
<td>Yamhill</td>
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Selected Zip Codes in the following Oregon counties:

<table>
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<th>County</th>
<th>Zip Codes</th>
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<tbody>
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<td>97420 97454 97490</td>
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