Evelyn Minor-Lawrence
Director

DEPARTMENT OF HUMAN RESOURCES

PUBLIC SERVICES BUILDING
2051 Kaen Road | Oregon City, OR 97045

April 16, 2019

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of 2020 Agreements with Providence Health Plan for
Administrative Services for Clackamas County's Self-Funded Medical Benefits

Purpose/Outcomes	Approval of the Clackamas County Providence Health Medical Benefit Plan Administrative Services Agreement for 2020 and five Summary Plan Descriptions for the 2020 plan year.
Dollar Amount and Fiscal Impact	The estimated fiscal impact for the 2020 plan year is: $39,456,716.40
Funding Source	Department, employee, and retiree contributions
Duration	Effective January 1, 2020 – December 31, 2020
Previous Board Action	This agreement received Board of County Commissioner's preliminary approval at the Board of County Commissioner's Policy Session on December 3, 2019.
County Counsel Review	This Administrative Services Agreement and the five summary plan descriptions have been reviewed and approved by County Counsel on April 1, 2020.
Strategic Plan Alignment	Builds public trust through good government.
Contact Person	Kristi Durham, Human Resources, 503.742.5470

BACKGROUND:
At the Policy Session on December 3, 2019, the Board of County Commissioners approved the 2020 benefit plan renewals. The Providence plan Administrative Services Agreement and the Summary Plan Descriptions require the board's approval and signature.

County Counsel has reviewed and approved the plan agreement and descriptions.

RECOMMENDATION:
Staff recommends the Board approve the 2020 Administrative Services Agreement and Summary Plan Descriptions from Providence Health Plan.

Sincerely,

Kristi Durham, Benefits Manager
Department of Human Resources

CLACKAMAS COUNTY GENERAL COUNTY EMPLOYEES

PERSONAL OPTION PLAN
SUMMARY PLAN DESCRIPTION

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1. INTRODUCTION

Statement from Plan Sponsor

Clackamas County has designed this Plan in cooperation with Providence Health Plan. The benefits under the Plan are provided by Clackamas County on a self-insured basis. Clackamas County has contracted with Providence Health Plan to process claims and provide customer service to Plan Members. However, Providence Health Plan does not insure or otherwise guarantee any benefits under the Plan.

Clackamas County Employee Services: 503-655-8459

Customer Service Quick Reference Guide:

Medical and prescription drug claims and benefits, and General assistance with your Plan	503-574-7500 (local / Portland area) 800-878-4445 (toll-free) 711 (TTY) www.ProvidenceHealthPlan.com
Mail order prescription drug services	www.Providence Health Plan
Medical Prior Authorization requests	800-638-0449 (toll-free)
Mental Health / Substance Abuse Prior Authorization	800-711-4577 (toll-free)
Providence Nurse Advice Line	503-574-6520 (local / Portland area) 800-700-0481 (toll-free) 711 (TTY)
Providence Resource Line To find a care provider or to register for Providence classes	503-574-6595
myProvidence Help Desk	503-216-6463 877-569-7768 (toll-free)
LifeBalance	503-234-1375 888-754-LIFE (toll-free) www.LifeBalanceProgram.com

1.1 KEY FEATURES OF YOUR CLACKAMAS COUNTY GENERAL COUNTY EMPLOYEES PERSONAL OPTION PLAN

- Some capitalized terms have special meanings. Please see section 15, Definitions.
- In this Summary Plan Description, Providence Health Plan and Clackamas County are referred to as "we," "us" or "our." Members enrolled under this Plan are referred to as "you" or "your."
- Coverage under this Plan is provided through:
- Our Providence Signature Network of In-Network Providers; and
- Providence Health Plan's national network of In-Network Providers.
- Covered Services must be obtained from In-Network Providers, with the following exceptions:
    - Emergency Services and Urgent Care Services, as specified in section 4.5;
    - Covered Services received by an enrolled Out-of-Area Dependent, as specified in section 3.5.2; and
    - Covered Services delivered by an Out-of-Network Provider when those Services have been approved in advance through the Prior Authorization procedures specified in section 3.7.
- All Members are encouraged to choose a Primary Care Provider who will provide preventive and primary care Services and coordinate other care in a convenient and cost-effective manner.
- A printable directory of In-Network Providers in our Service Area is available at http://phppd.providence.org/. Members without Internet access or who would like a hard copy of our Provider Directory may contact Customer Service for assistance.
- Certain Covered Services require an approved Prior Authorization, as specified in section 3.7.
- Coverage limitations and exclusions apply to certain Services, as stated in sections 3, 4, and 5 and the Benefit Summary.
- Coverage under this Plan is available 24 hours a day, seven days a week and during periods of domestic or foreign travel.
- All Covered Services are subject to the provisions, limitations and exclusions that are specified in Plan documents. You should read the provisions, limitation and exclusions before seeking Covered Services because not all health care services are covered by this Plan.
- This Plan consists of this Summary Plan Description plus the Benefit Summary(ies), any Endorsements or amendments that accompany these documents, the agreement between Providence Health Plan and the Plan Sponsor (if any), and those policies maintained by Providence Health Plan which clarify any of these documents. In the event of any conflict between these documents, they are to be interpreted in the following order of priority: (1) Endorsements and amendments, (2) Providence Health Plan/ Plan Sponsor agreement, (3) Summary Plan Description, (4) Benefit Summary(ies), and (5) applicable Providence Health Plan policies.

2. WELCOME TO PROVIDENCE HEALTH PLAN

Thank you for choosing Providence Health Plan. We look forward to meeting your health care needs. Providence Health Plan is an Oregon licensed Health Care Services Contractor whose parent company is Providence Health & Services. Our goal is to help improve the health status of individuals in the communities in which we serve. This booklet contains important information about the health plan coverage offered to Clackamas County General County Employees and their Dependents.

2.1 CLACKAMAS COUNTY GENERAL COUNTY EMPLOYEES PERSONAL OPTION PLAN

Your Plan allows you to receive Covered Services from In-Network Providers.

It is your responsibility to verify whether or not a physician/provider, Hospital or other facility is participating with Providence Health Plan, and whether or not the health care is a Covered Service even if you have been directed or referred for care by an In-Network Provider.

If you are unsure about a physician/provider's, Hospital's or other facility's participation with Providence Health Plan, visit our Provider Directory, available online at http://phppd.providence.org/, before you make an appointment. You can also call Customer Service to get information about a provider's participation with Providence Health Plan and your benefits.

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 an estimate of what you may owe at the time you receive services, and bill or credit you for the balance later.

2.2 SUMMARY PLAN DESCRIPTION

This Summary Plan Description contains important information about the health plan coverage offered to employees of Clackamas County. It is important to read this Summary Plan Description carefully as it explains your Plan benefits and Member responsibilities. If you do not understand a term that is used, you may find it in Definitions, section 15. If you need additional help understanding anything in this Summary Plan Description, please call Customer Service at 503-574-7500 or 800-878-4445. *See section 2.3 for additional information on how to reach Customer Service.*

This Summary Plan Description is not complete without your:

- Clackamas County General County Personal Option Medical Benefit Summary and any other Benefit Summary documents issued with this Plan. These documents are available at www.ProvidenceHealthPlan.com when you register for a myProvidence account as explained in section 2.4. Benefit Summaries detail your Deductible, Copayments and Coinsurance for Covered Services and also provide other important information.

- **Provider Directory** which lists In-Network Providers, available online at http://phppd.providence.org/. If you do not have Internet access, please call Customer Service or check with your Employer's human resource department to obtain a hard copy of the directory.

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

2.3 CUSTOMER SERVICE

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

Questions or concerns about your health care or service.

Contacting Providence Customer Service

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

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

You may **access claims and benefit information 24 hours a day, seven days a week** 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 Summary Plan Description 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. If you have questions or need assistance registering for or accessing an existing account, contact myProvidence customer service at 877-569-7768

2.5 YOUR MEMBER ID CARD

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

- Your Member number and group number
- 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 Plan.

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

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

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

2.6 PROVIDENCE NURSE ADVICE LINE

503-574-6520; toll-free 800-700-0481; TTY 711

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

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

Please have your Member ID Card available when you call.

2.7 WELLNESS BENEFITS

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

Providence Resource Line is your connection to information and services on classes, self-help materials, tobacco-use cessation services, and for referrals to Providence Health Plan In-Network Providers and to Providence Health & Services programs and services. Services and health-education vary by geographic service area.

Health Education

Providence Health Plan offers a wide variety of classes to help you achieve healthy lifestyle and wellness goals. We can assist you in learning to eat right and manage your weight, prepare for childbirth and much more. If you have diabetes, health education classes also are available (see section 4.1.6 for further information).

Providence Health Plan Members receive discounts on health education classes. Your costs, services and the health education classes available may vary by geographic-service area. For more information on classes available in your area, call the Providence Resource Line at 503-574-6595 or 800-562-8964 or visit www.providence.org/classes.

Health Coaching

Providence Health Plan offers Members free coaching support for weight loss, diabetes prevention, nutrition, stress management, exercise, sleep and tobacco cessation. For more information on health coaching, call 503-574-6000 (TTY: 711) or 888-819-8999 or visit www.ProvidenceHealthPlan.com/healthcoach.

Care Management
Providence Care Management provides Members with information and assistance with healthcare navigation, as well as managing chronic conditions from a Registered Nurse Care Manager.

You can access these Services by calling 800-662-1121 or e-mailing caremanagement@providence.org.

Tobacco Use Cessation
Your Wellness Benefits include access to tobacco-use cessation programs provided through our Providence Health & Services Hospitals as well as through Quit for Life. These programs address tobacco dependence through a clinically proven, comprehensive approach to tobacco-use cessation that treats all three aspects of tobacco use – physical addiction, psychological dependence and behavioral patterns. (See section 4.1.8 regarding coverage for tobacco-use cessation Services).

More information about our Tobacco-Use Cessation programs can be found online at http://www.providence.org/healthplans/members/healthbalance/smokingcessation.aspx, or by calling 503-574-6595 or 800-562-8964.

Quit for Life can be reached at 866-QUIT-4-LIFE (784-8454), 5 a.m. through 9 p.m. (Pacific Time), seven days a week.

Wellness information on our website — www.ProvidenceHealthPlan.com
Visit Providence Health Plan online at www.ProvidenceHealthPlan.com for medical information, class information, information on extra values and discounts and a wide array of other information described with your good health in mind. You also may set up your own myProvidence account to gain access to your specific personal health plan information. See *Registering for a myProvidence account*, section 2.4 for more details.

LifeBalance — 503-234-1375 or 888-754-LIFE www.LifeBalanceProgram.com
This program offers exclusive discounts to Providence Health Plan Members on a wide variety of health and wellness programs, as well as recreational, cultural and wellness activities. You can save on professional instruction, fitness club memberships, yoga classes, and much more. You also have access to discounted events, such as white-water rafting, ski trips, theater nights, and sporting events.

Learn more by visiting the LifeBalance website at www.LifeBalanceProgram.com or calling LifeBalance at 503-234-1375 or 888-754-LIFE. Please have your Providence Health Plan Member ID Card ready when you request LifeBalance discounts.

Assist America
Your wellness benefits include access to travel assistance services and identity theft protection services.

Travel Assistance Services include emergency logistical support to members traveling internationally or people traveling 100 miles from home. Learn more by visiting www.assistamerica.com or calling Assist America at 609-986-1234 or 800-872-1414.

Assist America also provides identity theft protection services for Providence Health Plan members. Please call 614-823-5227 or 877-409-9597 or visit www.assistamerica.com/Identity-Protection/Login to sign up for the program. Please have your Providence Health Plan Member ID card ready, and tell them your code is 01-AA-PRV-01193.

2.8 PRIVACY OF MEMBER INFORMATION

At Providence Health Plan, we respect the privacy and confidentiality of your protected health information (PHI). We are required by law to maintain the privacy of your protected health information, (commonly called PHI or your personal information) including in electronic format. When we use the term "personal information," we mean information that identifies you as an individual (such as your name and Social Security Number, as well as financial, health and other information about you that is nonpublic), which we obtain so we can provide you with the benefits and coverage under your Employer's plan. Providence Health Plan maintains policies that protect the confidentiality of personal information, including Social Security numbers, obtained from its Members in the course of its regular business functions.

Members may request to see or obtain their medical records from their provider. Call your physician's or provider's office to ask how to receive a copy.

For more information about uses and disclosures of Member information, including uses and disclosures required by law, please refer to our Notice of Privacy Practices. A copy is available at https://healthplans.providence.org/members/rights-notices or by calling Customer Service.

Appointment of Authorized Representative

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

Confidentiality and your Employer

In accordance with the federal privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), Providence Health Plan will not disclose a Member's protected health information (PHI) to the Employer or any agent of the Employer unless requested for the HIPAA allowed purpose of the Employer's obtaining bids from other health plans for further health coverage or for the Employer's modifying, amending, or terminating any benefit under the health plan. In these circumstances, Providence Health Plan may release summary health information, which is PHI from which your name, ID number, dates smaller than a year, and certain other identifiers have been removed.

Providence Health Plan may disclose a Member's PHI to an employer or any agent of the Employer if the disclosure is:

1. In compliance with the applicable provisions of HIPAA; and
2. Due to a HIPAA compliant authorization, the Member has completed to allow the Employer access to the Member's PHI; or
3. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer. The details of this required certification can be reviewed at https://healthplans.providence.org/about-us/privacy-notices-policies/protected-health-information-and-your-employer/.

Providence Health Plan will disclose a Member's PHI with whom and in ways permitted by HIPAA. These uses are covered in detail in Providence Health Plan's Notice of Privacy Practices available online, or by mail if you request it.

3. HOW TO USE YOUR PLAN

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

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

3.1 IN-NETWORK PROVIDERS

Providence Health Plan has contractual arrangements with certain physicians/providers, hospitals and facilities. Our agreements with these "In-Network Providers" enable you to receive quality health care for a reasonable cost.

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

3.1.1 Nationwide Network of In-Network Providers

Providence Health Plan also has contractual arrangements with certain Qualified Practitioners, Hospitals and facilities nationwide. These arrangements allow you to receive Services when using In-Network Providers, even when you are outside of Oregon and southwest Washington.

3.1.2 Choosing an In-Network Provider

To choose an In-Network Provider, or to verify if a provider is an In-Network Provider, please refer to the Provider Directory, available online at http://phppd.providence.org/. If you do not have access to our website, please call Customer Service to request an In-Network Provider Information.

Your In-Network 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 3.7.

3.1.3 Indian Health Services Providers

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

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

3.2 THE ROLE OF A PRIMARY CARE PROVIDER

To encourage optimum health, we promote wellness and preventive care. We also believe wellness and overall health is enhanced by working closely with one physician or provider – your Primary Care Provider. Your Primary Care Provider 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 an In-Network Primary Care Provider as soon as possible.

3.2.1 Primary Care Providers

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

Primary Care Providers provide preventive care and health screenings, 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 Primary Care Providers offer maternity care and minor outpatient surgery as well.

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

3.2.2 Established Patients with Primary Care Providers

If you and your family already see a provider, you may want to check the provider directory to see if your provider is an In-Network Primary Care Provider for Providence Health Plan. If your provider is participating with us, let his or her office know you are now a Providence Health Plan Member.

3.2.3 Selecting a New Primary Care Provider

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

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

Let your Primary Care Provider know if you are under a specialist's care as well as if you are currently taking any ongoing prescription medications.

3.2.4 Changing Your Primary Care Provider

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

3.2.5 Office Visits

Primary Care Providers

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

Specialists

Your Primary Care Provider will discuss with you the need for diagnostic tests or other specialist services; and may also recommend you see a specialist for your treatment.

You also may decide to see a specialist without consulting your Primary Care Provider. Visit the Provider Directory, available online at http://phppd.providence.org/, or call Customer Service to choose a specialist who is an In-Network Provider with Providence Health Plan.

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

Whenever you visit a specialist:

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

Alternative Care Providers

This Plan includes coverage for office visits to alternative care providers, as listed in your Benefit Summary. See section 15 for the definition of Alternative Care Provider. For coverage of chiropractic manipulation and acupuncture, see sections 4.12.9, 4.12.10 and your Benefit Summary.

3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS

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

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

IMPORTANT NOTE: Your Plan only pays for Covered Services received from Prior Authorized Out-of-Network Providers at Usual, Customary, and Reasonable rates (UCR) (see Section 15, Definitions). If the approved, Prior Authorized Out-of-Network Provider charges more than the UCR rates allowed under your Plan, that provider may bill you directly for the additional amount that is not covered by your Plan. That amount is in addition to any Deductible, Copayment, or Coinsurance for which you may be responsible, and does not accrue to your Out-of-Pocket Maximum.

If you choose to receive Covered Services from an approved, Prior Authorized Out-of-Network Provider, those Services are still subject to the terms of this Summary Plan Description. Your Plan will only pay for Medically Necessary Covered Services. No matter what type of provider you see, the treatments, supplies, and medications excluded by this Plan are not covered.

It is important for you to understand that Providence Health Plan has not assessed the approved, Prior Authorized Out-of-Network Provider's credentials or quality; nor has Providence Health Plan reviewed and verified the Out-of-Network Provider's qualifications and history for information such as: relevant training, licensure, certification, and/or registration to practice in a health care field, and academic background. Additionally, the Out-of-Network Provider will not have been assessed by Providence Health Plan to verify that the provider meets certain criteria relating to professional competence and conduct and as such is not guaranteed to follow your benefit plan, rules, regulations, or guidelines with regard to standards of care nor standards of documentation and billing.

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

After you meet your Deductible, if applicable, and if the Services provided are Medically Necessary Covered Services, we will provide payment to Out-of-Network Providers according to Usual, Customary and Reasonable (UCR) charges. UCR charges do not include sales taxes, handling fees and similar surcharges; such taxes, fees and surcharges are not covered expenses. Charges which exceed UCR are the Member's responsibility and are not applied to the Out-of-Pocket Maximum. See section 15 for the definition of UCR.

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

	Provider's Status	
Item	In-Network	Out-of-Network
Provider's standard charges	$100	$100
Allowable charges under this Plan	$80 (contracted)	$80 (if that is UCR)
Plan benefits (for this example only)	$64 (if 80% benefit)	$56 (if 70% benefit)
Balance you owe	$16	$24
Additional amount that the provider may bill to you	$-0-	$20 ($100 minus $80)
Total amount you would pay	$16	$44 ($24 plus $20)

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

Payment for Covered Services Provided Before Disposition of Criminal Charges

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

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

- Diagnostic tests or health evaluations required by the corrections agency, as a matter of course, for all individuals who are in the custody of the county pending the disposition of charges;
- Hospital and ambulatory surgical center services, except as rendered by an In-Network provider.

3.4 MOVING INTO OR OUT OF THE SERVICE AREA

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

3.5 OUT-OF-AREA DEPENDENTS

Dependents of a subscriber on a Personal Option Plan who live outside the Providence Health Plan Service Area (including dependents who are away at school) are eligible to become Out-of-Area Dependent Members. *See "Definitions" section 15, for the definition of "Eligible Family Dependent" and "Out-of-Area Dependent."* This section discusses how Enrolled Out-of-Area Dependent Personal Option Plan Members obtain covered services through Providence Health Plan's enrolled Out-of-Area Dependent benefit.

3.5.1 Out-of-Area Dependent Enrollment

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

3.5.2 Out-of-Area Dependent Coverage

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

You must purchase your prescription drugs at one of our nationwide Participating Pharmacies (see section 4.14.1. A list of our Participating Pharmacies is available online at www.ProvidenceHealthPlan.com. You also may contact Customer Service if you need help locating a Participating Pharmacy near you or when you are away from your home. See your Benefit Summary for details on your Copayment and Coinsurance, if applicable, and on how to use this benefit.

3.5.3 Out-of-Area Dependents and Change of Status

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

3.5.4 Out-of-Area Dependents Prior Authorization

Enrolled Out-of-Area Dependents are responsible for obtaining Prior Authorization from Providence Health Plan prior to receiving certain services from Out-of-Network Providers. For further information about Prior Authorization, including a list of these Covered Services and how to obtain Prior Authorization, see section 3.7.

You must contact us to obtain Prior Authorization for specified Covered Services if the Services are to be received from an Out-of-Network Provider. See section 3.7.

3.6 NOTICE OF PROVIDER TERMINATION

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

3.7 PRIOR AUTHORIZATION

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

Services received from In-Network Providers:
When Services are received from an In-Network Provider, the In-Network Provider is responsible for obtaining Prior Authorization.

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

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.
- Anesthesia Care with Diagnostic Endoscopy.
- All Travel Expense Reimbursement, as provided in section 3.8.
- All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services for Mental Health and Substance Abuse, as provided in sections 4.10.1 and 4.10.3.
- All Applied Behavior Analysis, as provided in section 4.10.2.
- All Human Organ/Tissue Transplant Services, as provided in section 4.13.
- All Restoration of Head/Facial Structures; Limited Dental Services, as provided in section 4.12.6.
- All Temporomandibular Joint (TMJ) Services, as provided in section 4.12.7.
- All High Tech Imaging, including PET, CT, CTA, MRI and MRA, Nuclear Cardiac Study Services, and echocardiography Services, as provided in section 4.4.1.
- All Sleep Study Services, as provided in section 4.4.2.
- Certain Home Health Care Services, as provided in section 4. 11.1.
- Certain Hospice Care Services, as provided in section 4.11.2.
- Certain Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment, as provided in section 4.9.
- All outpatient hospitalization and anesthesia for dental Services, as provided in section 4.12.6.
- All Genetic Testing Services, as provided in section 4.12.1.
- Certain medications, including certain immunizations, received in your Provider's office, as provided is sections 4.3.5 and 4.1.2.
- Certain prescription drugs specified in our Formulary, as provided in section 4.14.1.
- Certain infused Prescription Drugs administered in a hospital-based infusion center, as provided in section 4.7.1.

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

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

Prior Authorization Requests for Out-of-Network Services:

- The Member or the Out-of-Network Provider must call us at 1-800-638-0449 to obtain Prior Authorization. Please have the following information ready when calling to request a Prior Authorization:
- The Member's name and date of birth.
- The Member's Providence Health Plan Member number and Group 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.

Failure to Obtain Prior Authorization:
If you do not obtain Prior Authorization for Services received from an Out-of-Network Provider, as specified in section 3.3, a 50% **penalty,** not to exceed $2,500 for each Covered Service, will be applied to the claim.

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

3.8 TRAVEL EXPENSE REIMBURSEMENT

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

3.9 MEDICAL COST MANAGEMENT

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

The Plan reserves the right to deny payment for Services that are not Medically Necessary in accordance with the criteria maintained by Providence Health Plan. When more than one medically appropriate alternative is available, Providence Health Plan will approve the least costly alternative.

In accordance with Providence Health Plan's medical cost management protocols and criteria specified in this paragraph, Providence Health Plan may approve substitutions for Covered Services under this Plan.

A Substituted Services must:

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

The Plan's coverage of a Substituted Service for any Member does not obligate the Plan to:

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

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

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

3.9.1 Coverage of New Technology and New Application of Existing Technology

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

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

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

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

- Technology must improve health outcomes. The beneficial effects must outweigh any harmful effects on health outcomes. It must improve the length of life, ability to function or quality of life.
- Technology must be as beneficial as any established alternative. It should improve the net health outcome as much, or more, than established alternatives.
- Application of technology must be appropriate, in keeping with good medical standards, and useful outside of investigational settings.
- Technology must meet government approval to market by appropriate regulatory agency as applicable.

- Criteria must be supported with information provided by well-conducted investigations published in peer-reviewed journals. The scientific evidence must document conclusions that are based on established medical facts.
- Opinions and evaluations of professional organizations, panels, or technology assessment bodies are evaluated based on the scientific quality of the supporting evidence.

Technology Evaluation Process

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

Expedited Review

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

3.10 MEDICALLY NECESSARY SERVICES

We believe our Members are entitled to comprehensive medical care within the standards of good medical practice. Providence Health Plan's medical directors and special committees of In-Network Providers determine which Services are Medically Necessary, as defined in section 15. Services that do not meet Medically Necessary criteria will not be covered.

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

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

3.11 APPROVED CLINICAL TRIALS

Benefits are provided for Covered Services directly related to a Member's participation in an Approved Clinical Trial offered through an In-Network provider.

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

You may choose to participate in an Approved Clinical Trial offered through an Out-of-Network provider. However, coverage will only be provided for Medically Necessary services received In-Network in treatment of an illness or injury.

The following costs are excluded:

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

The Plan does not discriminate against a Member who participates in a clinical trial, whether or not the trial is an Approved Clinical Trial. The Plan provides benefits for services unrelated to a clinical trial to the extent that the services are otherwise Covered Services under the Plan.

3.12 HOW BENEFITS ARE APPLIED

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

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

3.13 DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS

Your Plan has a Deductible and an Out-of-Pocket Maximum, as stated in your Benefit Summary.

Deductible amounts apply to Out-of-Pocket Maximums.

3.13.1 Understanding Deductibles

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

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

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

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

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

Your Costs that Do Not Apply to Deductibles: The following out-of-pocket costs do not apply towards Your Individual and Family Deductibles:

- Services not covered by this Plan.
- Services in excess of any maximum benefit limit.
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges.
- Any penalties you must pay if you do not follow Providence Health Plan's Prior Authorization requirements.
- Copayments or Coinsurance specified as not applicable toward the Deductible in any Benefit Summary issued with this Plan.

3.13.2 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 Plan. See your Benefit Summary.

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

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

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

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

- Services not covered by this Plan;
- Services not covered because Prior Authorization was not obtained, as required in section 3.7;
- Services in excess of any maximum benefit limit;
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges;
- Deductibles, Copayments or Coinsurance for a Covered Service if indicated in any Benefit Summary as not applicable to the Out-of-Pocket Maximum; and
- Any penalties you must pay if you do not follow Providence Health Plan's Prior Authorization requirements.

IMPORTANT NOTE: Some Benefits are NOT eligible for 100% benefit coverage. The Copayment or Coinsurance for these Services, as shown in the Benefit Summary, remains in effect throughout the Calendar Year.

4. COVERED SERVICES

This section describes Services that, when Medically Necessary and not otherwise excluded or limited, are covered under this Plan.

Please refer to your Benefit Summary for details of your specific coverage. You can view your Member materials by registering for a myProvidence account on our website at www.ProvidenceHealthPlan.com (see section 2.4). If Clackamas County modifies your benefits, you will be notified in writing of the changes.

You must use In-Network Providers to receive the Covered Services listed in this section, unless you are an Enrolled Out-of-Area Dependent or have received Prior Authorization to receive services from an Out-of-Network Provider.

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

4.1 PREVENTIVE SERVICES

Preventive Services are covered as shown in the Benefit Summary. For Women's Preventive Health Care Services, see section4.2.
In accordance with the Patient Protection and Affordable Care Act of 2010 and related legislation, your Plan covers the following Services in full when received from In-Network Providers:

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

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

4.1.1 Physical Examinations and Well-Baby Care

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

Recommended Guidelines:

Infants up to 30 months:	Up to 12 well-baby visits.
Children and Adolescents:	
3 years through 21 years:	One exam every year.
Adults:	
22 years through 29 years:	One exam every five years.
30 years through 49 years:	One exam every two years.
50 years and older:	One exam every year.

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

Covered Services do **NOT** include the following:

1. Services for laser surgery, radial keratotomy and any other surgery to correct myopia, hyperopia or stigmatic error, vision therapy, orthoptic treatment (eye exercises);
2. Services for routine eye and vision care, refractive disorders, eyeglass frames and lenses, contact lenses; and
3. Hearing aids, including all Services related to the examination and fitting of hearing aids; except as specified in section 4.12.14.

4.1.2 Immunizations and Vaccinations

Benefits for immunizations and vaccinations are provided in accordance with accepted medical practice. Visits to your Qualified Practitioner's office or Participating Pharmacy for immunizations or injections are subject to the Copayment or Coinsurance shown in the Benefit Summary. Some immunizations may require Prior Authorization, as listed in the Medical benefit drug prior authorization list available on our website at https://healthplans.providence.org/members/pharmacy-resources/Pages/default.aspx or by calling Customer Service.

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

4.1.3 Prostate Cancer Screening Exams

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

4.1.4 Colorectal Cancer Screening Exams

Benefits for colorectal cancer screening examinations include:

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

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

All colonoscopy and sigmoidoscopy Services are covered in full, including prescription drug bowel prep kits as listed in our Formulary.

4.1.5 Preventive Services for Members with Diabetes

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

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

4.1.6 Diabetes Self-Management Education Program

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

4.1.7 Nutritional Counseling

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

4.1.8 Tobacco Use Cessation Services

Coverage is provided for participation in a Providence Health Plan-approved, physician-recommended tobacco use cessation program that follows the United States Public Health Service guidelines. “Tobacco use cessation program” includes educational and medical treatment components such as, but not limited to, counseling, classes, nicotine replacement therapy and prescription drugs designed to assist Members in ceasing the use of tobacco products. A list of Providence Health Plan-approved programs is available online at www.ProvidenceHealthPlan.com (select “search” and enter “tobacco cessation” or by calling Customer Service at 503-574-7500 or 800-878-4445.

4.2 WOMEN’S PREVENTIVE HEALTH CARE SERVICES

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