0122 to 0123 ASO Contract Comparison – ACA non-grandfathered plans (non-GR)

Option Advantage, Personal Option, HSA-Qualified, Choice, Connect

DRAFT –10/28/2022

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Category A: Benefit Changes – For all plan types, except as otherwise denoted								
Maternity Services for Donor Breast Milk	All Handbooks	Addition of coverage for medically necessary donor breast milk for Maternity Services.	**4.8 MATERNITY SERVICES** ********** ***Maternity support services:*** Members may attend a class to prepare for childbirth. The classes are held at In-Network Hospitals. Call the Providence Resource Line at 503-574-6595 or visit www.providence.org/classes for information on classes, specific dates, locations, registration and prices. Classes vary by geographic area. In addition, Members with high-risk pregnancies may receive support services through care or case management. A care manager may be a social worker or a registered nurse. ***Diabetes coverage during pregnancy:*** During pregnancy through six weeks postpartum, the Plan provides coverage in full for diabetes services, medications, and supplies when received In-Network.	**4.8 MATERNITY SERVICES** ********** ***Maternity support services:*** Members may attend a class to prepare for childbirth. The classes are held at In-Network Hospitals. Call the Providence Resource Line at 503-574-6595 or visit www.providence.org/classes for information on classes, specific dates, locations, registration and prices. Classes vary by geographic area. In addition, Members with high-risk pregnancies may receive support services through care or case management. A care manager may be a social worker or a registered nurse. ***Diabetes coverage during pregnancy:*** During pregnancy through six weeks postpartum, the Plan provides coverage in full for diabetes services, medications, and supplies when received In-Network. ***Donor breast milk coverage:*** For infants medically or physically unable to receive maternal human milk or participate in chest feeding, or whose parent is medically or physically unable to produce maternal human milk in sufficient quantities or caloric density or participate in chest feeding, the Plan provides coverage for medically necessary donor human milk for inpatient use, when ordered by a licensed health care provider with prescriptive authority, or by an International Board Certified Lactation Consultant (IBCLC) certified by the International Board of Lactation Consultant Examiners.	Yes	Yes, WA State SB 5702	This change **only applies** to non-ERISA ASO governmental groups that are either required to or choose to follow state mandates. It is otherwise completely *optional* for traditional ERISA-subject ASO groups. Washington State Senate Bill 5702 mandates coverage for donor breast milk for inpatient use when medically necessary for infants.	☐ Yes ☐ No

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Specialty Pharmacy Variable Copay Program	Non-HSA Handbooks only	Adding section explaining manufacturer-funded financial assistance programs such as Smart RxAssist, and detailing how they apply to pharmacy benefit.	N/A	4.14.10 Specialty Pharmacy Variable Copay Program Many specialty medications have manufacturer programs which provide financial assistance to patients in the purchase of the medication. When a financial assistance program is available from a prescription drug manufacturer for a specialty medication, [YOUR COMPANY] requires that you participate in the program. Failure to complete the enrollment process for participation will result in a higher copayment/coinsurance and/or penalty, which can exceed the regular plan benefit cost shares. Manufacturer-funded financial assistance will not be considered true out of pocket costs for plan participants and will not apply to out of pocket deductible maximums. Only your actual out-of-pocket payments will count toward your deductible or out-of-pocket maximum. For medications not subject to this program, regular plan benefits will apply. Due to federal regulation, Health Savings Account (HSA) plans are not eligible for this program.	Yes	No	**Note:** Acceptance of the new benefit is *optional.* There is no requirement for self-funded plans to adopt Smart RxAssist. Additionally, for groups accepting Smart RxAssist **this language addition is also optional** for groups electing to accept the new program. PHP recommends adoption of this language for purposes of clarity of coverage if the program is adopted.	☐ Yes ☐ No
Orthoptics and Vision Therapy	All Handbooks	Removing Orthoptics from Vision Services exclusion list and moving new Vision Therapy section into "Other Covered Services"	**Exclusions that apply to Vision Services:** ********** • Services for routine eye care and vision care, vision exams/screenings, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in sections 4.1.1, 4.1.5, 4.5.3 and 4.9.2 and, if applicable, as covered under the Vision Supplemental Benefit; and • Orthoptics and vision training.	**5. EXCLUSIONS** **Exclusions that apply to Vision Services:** ********** • Services for routine eye care and vision care, vision exams/screenings, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in sections 4.1.1, 4.1.5, 4.5.3 and 4.9.2 and, if applicable, as covered under the Vision Supplemental Benefit; and • ~~Orthoptics and v~~ Vision training, except as provided in section 4.12.16. ********** **4.12.16 Vision Therapy.** Coverage is provided, as shown in the Benefit Summary for Vision Therapy to treat Convergence Insufficiency. Services must be Medically Necessary and within the Qualified Practitioner's scope of license	Yes	No	**Note:** Acceptance is *optional*, however, PHP recommends adoption to provide a better benefit for members.	☐ Yes ☐ No

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Providence Health Plan

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Insulin cost share cap	HSA and Pharmacy Summaries Only	Prescription Drugs section, increase to insulin cost share cap, waiving Deductible for OR Prescription Drugs section, decrease to insulin cost share cap for WA	**Prescription Drugs** (Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies) Safe Harbor drugs are exempt from the deductible, subject to the formulary and applicable tier cost share **(Insulin cost share capped at $75 for a 30-day supply after Deductible is met.)** ********** **Prescription Drugs** (Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies) Safe Harbor drugs are exempt from the deductible, subject to the formulary and applicable tier cost share **(Insulin cost share capped at $100 for a 30-day supply. Deductible does not apply.)**	**Prescription Drugs** (Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies) Safe Harbor drugs are exempt from the deductible, subject to the formulary and applicable tier cost share **(Insulin cost share capped at $~~75~~80 for a 30 day supply. ~~after~~ Deductible ~~is met~~does not apply.)** ********** **Prescription Drugs** (Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies) Safe Harbor drugs are exempt from the deductible, subject to the formulary and applicable tier cost share **(Insulin cost share capped at $~~100~~35 for a 30-day supply. Deductible does not apply.)**	Yes	Yes, Oregon HB 2623 and OAR 836-053-0025 Washington state SB 5546	This change **only applies** to non-ERISA ASO governmental groups that are either required to or choose to follow state mandates. It is otherwise completely *optional* for traditional ERISA-subject ASO groups.	☐ Yes ☐ No
Removing "unmarried" from Eligible Family Dependent definition	All Handbooks	Removing "unmarried" from Eligible Family dependent definition.	**14. DEFINITIONS** The following are definitions of important terms used in this Plan and appear throughout as Capitalized text. **** **Eligible Family Dependent (Dependent)** **** 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 prior to the limiting age; and 3. Unmarried.	**14. DEFINITIONS** The following are definitions of important terms used in this Plan and appear throughout as Capitalized text. **** **Eligible Family Dependent (Dependent)** **** A covered Dependent child who attains the limiting age remains eligible if the child is: 1. Developmentally or physically disabled; and 2. Incapable of self-sustaining employment prior to the limiting age; ~~and~~ ~~3. Unmarried.~~	No	Yes, SB 748	This change **only applies** to non-ERISA ASO governmental groups that are either required to or choose to follow state mandates. It is otherwise completely *optional* for traditional ERISA-subject ASO groups.	☐ Yes ☐ No

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Category B: Benefit Administration Changes – For all plan types, except as otherwise denoted								
Adding eviCore PA language	Groups who use eviCore for Outpatient Rehabilitation PA managem-ent	Adding language that describes PHP uses eviCore for PA of physical therapy and occupational therapy services	**4.7.2 Outpatient Rehabilitative Services** Benefits are included for outpatient physical, occupational and speech therapy Covered Services provided by a physician or licensed/registered therapist, as stated in the Benefit Summary, to restore or improve lost function following illness or injury. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition and are subject to the visit benefit maximum stated in the Benefit Summary. A visit is considered treatment with one provider (e.g., if you see a physical therapist and a speech therapist the same day at the same facility, it counts as two visits as you have received treatment from two providers). Limits do not apply to Mental Health Covered Services. All Services are subject to review for Medical Necessity.	**4.7.2 Outpatient Rehabilitative Services** Benefits are included for outpatient physical, occupational and speech therapy Covered Services provided by a physician or licensed/registered therapist, as stated in the Benefit Summary, to restore or improve lost function following illness or injury. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition and are subject to the visit benefit maximum stated in the Benefit Summary. A visit is considered treatment with one provider (e.g., if you see a physical therapist and a speech therapist the same day at the same facility, it counts as two visits as you have received treatment from two providers). Limits do not apply to Mental Health Covered Services. All Services are subject to review for Medical Necessity. Providers make notifications for outpatient rehabilitation services through an authorizing agent. A notification is the initial request submitted to the authorizing agent to inform Providence Health Plan that you are starting physical therapy and/or occupational therapy services. The authorizing agent determines if the requests are approved or require medical necessity review. For more information, visit our website at ProvidenceHealthPlan.com/OutpatientRehab.	Yes	No	For ASO groups that currently use eviCore for Prior Authorization of physical therapy and occupational therapy services ONLY. If you do not use eviCore for this purpose, this change does NOT apply to you. We are adding language to state that we use an authorizing agent (eviCore) for PT and OT services, and also adding a link that directs to our website for more information about eviCore.	
Breastfeeding Counseling and Support	All Handbooks	Updating section to specify provider types whose services qualify for coverage.	**5.3.1 Breastfeeding Counseling and Support** Coverage for lactation counseling is provided when Medically Necessary as determined by the Qualified Practitioner. Benefits include coverage in full for breast pump equipment and supplies when rented or purchased through our Network Medical Equipment Providers. Out-of-Network, coverage is subject to your Durable Medical Equipment (DME) benefits.	**5.3.1 Breastfeeding Counseling and Support** Coverage for lactation counseling is provided when Medically Necessary, ~~as determined by the Qualified Practitioner~~ and performed by one of the following licensed providers: Nurse Practitioner (NP), Certified Nurse Mid-wife (CNM), Medical Doctor (MD), Doctor of Osteopathic Medicine, Naturopath (ND), Lactation Consultants, or Physicians Assistant (PA). Benefits include coverage in full for breast pump equipment and supplies when rented or purchased through our Network Medical Equipment Providers. Out-of-Network, coverage is subject to your Durable Medical Equipment (DME) benefits.	Yes	No	Updating section to specify which provider types qualify for coverage to better align with medical policy.	

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Prescription Drug Exclusions removal	All Handbooks	Removing exclusion for medications, drugs, or hormones for stimulating growth.	**13.1.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: 1. Drugs or medicines delivered, injected or administered to you by a physician or other provider or another trained person (see section 4.3.5); 2. Medications, drugs or hormones prescribed to stimulate growth, except when there is a laboratory-confirmed diagnosis of growth hormone deficiency for children through 18 years of age and when prescribed for the treatment of documented pituitary destruction in adults; 3. Drugs prescribed that do not relate to the prevention or treatment of a covered illness or injury;	**13.1.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: 1. Drugs or medicines delivered, injected or administered to you by a physician or other provider or another trained person (see section 4.3.5); ~~2. Medications, drugs or hormones prescribed to stimulate growth, except when there is a laboratory-confirmed diagnosis of growth hormone deficiency for children through 18 years of age and when prescribed for the treatment of documented pituitary destruction in adults;~~ 2. Drugs prescribed that do not relate to the prevention or treatment of a covered illness or injury;	Yes	No	This is a business decision to retire this exclusion in order to better align with medical policy.	
Category C: Language Changes Only – For all plan types, except as otherwise denoted								
Nurse Advice Phone number	All Handbooks	Update to local phone number for Nurse advice line	**1. INTRODUCTION** ********** Providence Nurse Advice Line 503-574-6520 (local / Portland area) ********** **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.	**1. INTRODUCTION** ********** Providence Nurse Advice Line 971-268-7951 ~~503-574-6520~~ (local / Portland area) ********** **2.6 PROVIDENCE NURSE ADVICE LINE** **971-268-7951 ~~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.	No	No	Update to local phone number for Nurse Advice line for members. No change to benefit.	

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Substance Use Disorder	All Handbooks	Changed defined term "Chemical Dependency" to "Substance Use Disorder"	PROVIDENCE HEALTH PLAN QUICK REFERENCE GUIDE **** Medical, Mental Health, and Chemical Dependency Prior Authorization requests **** **2.5 YOUR MEMBER ID CARD** **** 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/Chemical Dependency Customer Service. • Call or correspond with Customer Service. • Call Providence RN medical advice line. • Visit your pharmacy for prescriptions. • Receive Immediate, Urgent or Emergency Care Services. **4.3.3 E-Mail Visits** **** • All communications in connection with Mental Health or Chemical Dependency Services, as provided in section 4.10. **** **4.5.4 Emergency Detoxification Services** Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a Chemical Dependency treatment program, as stated in section 4.10.3, at the time Services are received. Prior Authorization is not required 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. If a Member is to be transferred to an In-Network Provider for continued inpatient care, the cost of Medically Necessary transportation will be covered. Continuing or follow-up care is not a Covered Service unless Prior Authorized by us.	PROVIDENCE HEALTH PLAN QUICK REFERENCE GUIDE **** Medical, Mental Health, and Chemical Dependency Prior Authorization requests **** **2.5 YOUR MEMBER ID CARD** **** 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/~~Chemical Dependency~~ Substance Use Disorder 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. **4.3.3 E-Mail Visits** **** • All communications in connection with Mental Health or ~~Chemical Dependency~~ Substance Use Disorder Services, as provided in section 4.10. **** **4.5.4 Emergency Detoxification Services** Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a ~~Chemical Dependency~~ Substance Use Disorder treatment program, as stated in section 4.10.3, at the time Services are received. Prior Authorization is not required 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. If a Member is to be transferred to an In-Network Provider for continued inpatient care, the cost of Medically Necessary transportation will be covered. Continuing or	No	Yes, HB 3046 Mental Health Parity	Language change only to replace out-of-date terminology, no change to benefit or administration of benefit.	

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			**** **4.10 MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES** **** **4.10.3 Chemical Dependency Services** Benefits are provided for Chemical Dependency Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions. **** **6.1.1 Timely Submission of Claims** **** Medical, Mental Health, and Chemical Dependency claims: **** **13 DEFINITIONS** **** **Chemical Dependency** Chemical Dependency means an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological or physical adjustment to common problems. Chemical Dependency does not mean an addiction to, or dependency on tobacco, tobacco products or foods. **** **Essential Health Benefits** Essential Health Benefits means the general categories of Services established under section 1302(b) of the	follow-up care is not a Covered Service unless Prior Authorized by us. **** **4.10 MENTAL HEALTH AND ~~CHEMICAL DEPENDENCY~~ SUBSTANCE USE DISORDER SERVICES** **** **4.10.3 ~~Chemical Dependency~~ Substance Use Disorder Services** Benefits are provided for ~~Chemical Dependency~~ Substance Use Disorder Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions. **** **6.1.1 Timely Submission of Claims** **** Medical, Mental Health, and ~~Chemical Dependency~~ Substance Use Disorder claims: **** **13 DEFINITIONS** **** **~~Chemical Dependency~~** ~~Chemical Dependency means an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological or physical adjustment to common problems. Chemical Dependency does not mean an addiction to, or dependency on tobacco, tobacco products or foods.~~ ****				

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			Patient Protection and Affordable Care Act (PPACA) and applicable regulations: • Ambulatory patient Services; • Emergency Services; • Hospitalization; • Maternity and newborn care; • Mental Health and substance use disorder (Chemical Dependency) Services, including behavioral health treatment; **** **Hospital** **** 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. **** **Medically Necessary** **** Prudent Clinical Judgment: The "prudent clinical judgment" standard of Medical Necessity ensures that Qualified Practitioners are able to use their expertise and exercise discretion, consistent with good medical care, in determining the Medical Necessity for health care Services to be provided to each Member. Covered Services may include, but are not limited to, medical, surgical, diagnostic tests, substance abuse treatment, other health care technologies, supplies, treatments, procedures, drug therapies or devices. **** **Mental Health** Mental Health means any mental disorder covered by diagnostic categories listed in the Diagnostic and	**Essential Health Benefits** Essential Health Benefits means the general categories of Services established under section 1302(b) of the Patient Protection and Affordable Care Act (PPACA) and applicable regulations: • Ambulatory patient Services; • Emergency Services; • Hospitalization; • Maternity and newborn care; • Mental Health and ~~s~~Substance ~~u~~Use ~~d~~Disorder ~~(Chemical Dependency)~~ Services, including behavioral health treatment; **** **Hospital** **** 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~~ Substance Use Disorder or Mental Health disorders. **** **Medically Necessary** **** Prudent Clinical Judgment: The "prudent clinical judgment" standard of Medical Necessity ensures that Qualified Practitioners are able to use their expertise and exercise discretion, consistent with good medical care, in determining the Medical Necessity for health care Services to be provided to each Member. Covered Services may include, but are not limited to, medical, surgical, diagnostic tests, ~~s~~Substance ~~a~~Abuse Disorder treatment, other health care technologies, supplies, treatments, procedures, drug therapies or devices. ****				

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			Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), such as, but not limited to, major depressive disorder, autism spectrum disorder, dissociative identity disorder, gender dysphoria, and substance use disorder. **** **Subscriber** Subscriber means an Eligible Employee who: a) works or resides in the Service Area; or b) works and resides outside* the Service Area; and c) is properly enrolled in accordance with our underwriting criteria and participation requirements. *Subscribers in this category are considered out-of-area Subscribers. **Urgent Care** Urgent Care means Services that are provided for unforeseen, non-life threatening, minor illnesses and injuries which require immediate attention, such as ear, nose and throat infections and minor sprains and lacerations.	**Mental Health** Mental Health means any mental disorder covered by diagnostic categories listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), such as, but not limited to, major depressive disorder, autism spectrum disorder, dissociative identity disorder, gender dysphoria, and ~~s~~Substance ~~u~~Use ~~d~~Disorder. **** **Subscriber** Subscriber means an Eligible Employee who: d) works or resides in the Service Area; or e) works and resides outside* the Service Area; and f) is properly enrolled in accordance with our underwriting criteria and participation requirements. *Subscribers in this category are considered out-of-area Subscribers. **Substance Use Disorder** Substance Use Disorder means an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological, or physical adjustment to common problems. Substance Use Disorder does not mean an addiction to, or dependency on tobacco, tobacco products or foods. **Urgent Care** Urgent Care means Services that are provided for unforeseen, non-life threatening, minor illnesses and injuries which require immediate attention, such as ear, nose and throat infections and minor sprains and lacerations.				
Maternity Services at Out of Network facilities	All Handbooks	Updating Covered Services to include Out-of-Network health	**4.8 MATERNITY SERVICES** ****	**4.8 MATERNITY SERVICES** ****	No	Yes, HB 4134	Clarifying language only. No change to benefit or administration of benefit.	

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		care facilities due to ongoing state or federally declared public health emergency.	**Covered Services include:** • Prenatal care; • Delivery at an approved facility or birthing center; • Postnatal care, including complications of pregnancy and delivery; • Emergency treatment for complications of pregnancy and unexpected pre-term birth; • Newborn nursery care*; and • Newborn nurse home visits** *Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit. **Newborn nurse home visits are provided for newborns up to 6 months of age, including foster and newly adopted newborns, for Oregon members residing in a community where the Oregon Health Authority (OHA) Universal Newborn Nurse Home Visiting Program is operating. Newborn nurse home visits are covered without member cost-share (unless required for the Plan to maintain HSA-qualified status) under the newborn's In-Network benefits and must be received from nurses certified by OHA to provide the services. ****	**Covered Services include:** • Prenatal care; • Delivery at an approved facility or birthing center*; • Postnatal care, including complications of pregnancy and delivery; • Emergency treatment for complications of pregnancy and unexpected pre-term birth; • Newborn nursery care**; and • Newborn nurse home visits*** *If you are diverted to an Out-of-Network health care facility due to an ongoing state or federally declared public health emergency, delivery services will be covered under your In-Network benefits. **Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit. ***Newborn nurse home visits are provided for newborns up to 6 months of age, including foster and newly adopted newborns, for Oregon members residing in a community where the Oregon Health Authority (OHA) Universal Newborn Nurse Home Visiting Program is operating. Newborn nurse home visits are covered without member cost-share (unless required for the Plan to maintain HSA-qualified status) under the newborn's In-Network benefits and must be received from nurses certified by OHA to provide the services. ****				
Online tools	All Handbooks	Adding clarifying language to Wellness	**2.7 WELLNESS BENEFITS** Providence Health Plan Members have access to the following wellness benefits: ********** • **Wellness information**	**2.7 WELLNESS BENEFITS** Providence Health Plan Members have access to the following wellness benefits: ********** • **Wellness information**	No	No	Added language specifying member benefits available as part of the Wellness Benefits program.	

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		information bullet.	o You can find medical information, class information, information on extra values and discounts and other information by visiting providence.org/healthplans.	o You can find medical information, class information, information on extra values such as online tools and discounts and other information by visiting ~~providence.org/healthplans~~ providencehealthplan.com.				
Section 3.11.1 Understanding Deductibles	HSA Handbooks only	Language removed to avoid confusion across lines of business	3.11.1 Understanding Deductibles ********** If you (or any enrolled Family Member) have a change in coverage with Providence Health Plan during the Calendar Year, with no interruption in coverage, any Deductible amount that you have incurred during the Calendar Year under the prior coverage will be credited to the new coverage as follows: • When you begin coverage under your HSA Qualified Plan; and • When you change from individual coverage to family coverage under your HSA Qualified Plan.	3.11.1 Understanding Deductibles ********** ~~If you (or any enrolled Family Member) have a change in coverage with Providence Health Plan during the Calendar Year, with no interruption in coverage, any Deductible amount that you have incurred during the Calendar Year under the prior coverage will be credited to the new coverage as follows:~~ • ~~When you begin coverage under your HSA Qaulified Plan; and~~ • ~~When you change from individual coverage to family coverage under your HSA Qualified Plan.~~	No	No	Removing language to better align with commercial lines of business. No change to benefit.	
Embedded HSA Deductibles	HSA Handbooks Only	Updating language to include embedded Deductibles, Out-of-Pocket Maximums, and Annual Limit on Cost Sharing to align with Large Group	3.11.1 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. ***Common In-Network and Out-of-Network Deductible:*** If your Plan has a **Common Deductible**, as listed in your Benefit Summary. **A Common Deductible applies to both In-Network and Out-of-Network benefits**. The Common Deductible can be met by using In-Network or Out-of-Network benefits, or a combination of both.	3.11.1 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. Deductibles can be Common, shared between In-Network and Out-of-Network benefits; or Separate, a different Deductible for In-Network vs. Out-of-Network benefits. Deductibles can be Aggregate, applying to all members or Embedded, applying to each Member.	Yes	No	Language clarification for 2023 explaining Embedded Deductibles for HSA Embedded plans to align with all commercial materials.	

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			Separate In-Network and Out-of-Network Deductibles: If your Plan has **Separate Deductibles**, it will be listed in your Benefit Summary. Your In-Network Deductible applies to Covered Services received using your In-Network Benefit, and your Out-of-Network Deductible applies to Covered Services received using your Out-of-Network benefit. **These In-Network and Out-of-Network Deductibles accumulate separately and are not combined.** ***Individual Deductible:*** An Individual Deductible is the amount shown in the Benefit Summary that applies when only one Member is enrolled in this Plan, and is the amount that must be paid by the Member before the Plan provides benefits for Covered Services for that Member. ***Family Deductible:*** The Family Deductible is the amount shown in the Benefit Summary that applies when two or more Family Members are enrolled in this Plan, and is the amount that must be paid before we provide benefits for any enrolled Family Members. All amounts paid by Family Members toward Covered Services apply toward the Family Deductible. When the Family Deductible is met, the Plan will begin paying for Covered Services for all enrolled Family Members. ***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; and • Copayments or Coinsurance specified as not applicable toward the Deductible in any Benefit Summary issued with this Plan. If you (or any enrolled Family Member) have a change in coverage with Providence Health Plan during the	Aggregate and Embedded Deductibles can be Common or Separate. ***Common In-Network and Out-of-Network Deductible:*** If your Plan has a **Common Deductible**, ~~as~~it will be listed in your Benefit Summary. **A Common Deductible applies to both In-Network and Out-of-Network benefits**. The Common Deductible can be met by using In-Network or Out-of-Network benefits, or a combination of both. ***Separate In-Network and Out-of-Network Deductibles:*** If your Plan has **Separate Deductibles**, it will be listed in your Benefit Summary. Your In-Network Deductible applies to Covered Services received using your In-Network Benefit, and your Out-of-Network Deductible applies to Covered Services received using your Out-of-Network benefit. **These In-Network and Out-of-Network Deductibles accumulate separately and are not combined.** *Aggregate Deductibles:* • ***Individual Deductible:*** An Individual Deductible is the amount shown in the Benefit Summary that applies when only one Member is enrolled in this Plan, and is the amount that must be paid by the Member before the Plan provides benefits for Covered Services for that Member. • ***Family Deductible:*** The Family Deductible is the amount shown in the Benefit Summary that applies when two or more Family Members are enrolled in this Plan, and is the amount that must be paid before ~~we~~the Plan provides benefits for any enrolled Family Members. All amounts paid by Family Members toward Covered Services apply toward the Family Deductible. When the Family Deductible is met, the Plan will begin paying for Covered Services for all enrolled Family Members. *Embedded Deductibles:*				

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			Calendar Year, with no interruption in coverage, any Deductible amount that you have incurred during the Calendar Year under the prior coverage will be credited to the new coverage as follows: • When you begin coverage under your Small Group Plan; and • When you change from individual coverage to family coverage under your Small Group Plan. 3.11.2 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. ***Common In-Network and Out-of-Network Out-of-Pocket Maximum:*** If your Plan has a Common In-Network and Out-of-Network Out-of-Pocket Maximum as listed in your Benefit Summary. The Common Out-of-Pocket Maximum can be met by payments you make for Covered Services using In-Network and Out-of-Network benefits. ***Separate In-Network and Out-of-Network Maximums:*** If your Plan has Separate In-Network and Out-of-Network Out-of-Pocket Maximums, it will be listed in your Benefit Summary. Your In-Network Out-of-Pocket Maximum can be met by payments you make for Covered Services received using your In-Network benefit, and your Out-of-Network Out-of-Pocket Maximum can be met by payments you make for Covered Services received using your Out-of-Network benefit. **These In-Network and Out-of-Network Out-of-Pocket Maximums accumulate separately and are not combined**. ***Individual Out-of-Pocket Maximum:*** The Individual Out-of-Pocket Maximum applies when only one Member is enrolled in the Plan, and means the total amount of Copayments, Coinsurance and Deductible that a Member must pay in a Calendar Year, as shown in the Benefit Summary, before we begin to pay 100% for	• ***Individual Deductible:*** An Individual Deductible is the amount shown in the Benefit Summary that applies regardless of how many members are enrolled, and is the amount that must be paid by the Member before the Plan provides benefits for Covered Services for that Member. • ***Family Deductible:*** The Family Deductible is the amount shown in the Benefit Summary that applies when two or more Family Members are enrolled in this 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; and • Copayments or Coinsurance specified as not applicable toward the Deductible in any Benefit Summary issued with this Plan. If you (or any enrolled Family Member) have a change in coverage with Providence Health Plan during the Calendar Year, with no interruption in coverage, any Deductible amount that you have incurred during the Calendar Year under the prior coverage will be credited to the new coverage as follows: • When you begin coverage under your Small Group Plan; and				

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			Covered Services for that Member within that Calendar Year. ***Family Out-of-Pocket Maximum:*** The Family Out-of-Pocket Maximum applies when two or more Family Members are enrolled in the Plan, and means the total amount of Copayments, Coinsurance and Deductible that a family must pay in a Calendar Year, as shown in the Benefit Summary, before we begin to pay 100% for Covered Services for any enrolled Family Members. The Family Out-of-Pocket Maximum can be met by the combined expenses of enrolled Family Members. Once the Family Out-of-Pocket Maximum is met, we will begin to pay 100% for Covered Services for enrolled Family Members within that Calendar Year. *Note*: Only Member expenses for Covered Services can be used to meet your Individual and Family Out-of-Pocket Maximums. ***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 3.5; • Services in excess of any maximum benefit limit; • Fees in excess of the Usual, Customary and Reasonable (UCR) charges; • Deductibles, Copayments or Coinsurance amounts for Adult Vision; • Deductibles, Copayments or Coinsurance amounts 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.	• When you change from individual coverage to family coverage under your Small Group Plan. 3.11.2 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. Out-of-Pocket Maximums can be Common, shared between In-Network and Out-of-Network benefits; or Separate, a different Out-of-Pocket Maximum for In-Network vs. Out-of-Network benefits. Out-of-Pocket Maximums can be Aggregate, applying to all members; or Embedded, applying to each Member. ***Common In-Network and Out-of-Network Out-of-Pocket Maximum:*** ~~If y~~Your Plan has a Common In-Network and Out-of-Network Out-of-Pocket Maximum as listed in your Benefit Summary. The Common Out-of-Pocket Maximum can be met by payments you make for Covered Services using In-Network and Out-of-Network benefits. ***Separate In-Network and Out-of-Network Maximums:*** If your Plan has Separate In-Network and Out-of-Network Out-of-Pocket Maximums, it will be listed in your Benefit Summary. Your In-Network Out-of-Pocket Maximum can be met by payments you make for Covered Services received using your In-Network benefit, and your Out-of-Network Out-of-Pocket Maximum can be met by payments you make for Covered Services received using your Out-of-Network benefit. **These In-Network and Out-of-Network Out-of-Pocket Maximums accumulate separately and are not combined**. ***Aggregate Out-of-Pocket Maximums:*** • ***Individual Out-of-Pocket Maximum:*** ~~The~~An Individual Out-of-Pocket Maximum applies when only one Member is enrolled in the Plan, and means the total amount of Copayments,				

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			IMPORTANT NOTE: Some Covered Services are NOT eligible for 100% benefit coverage. If a Covered Service is indicated as not applying toward the Out-of-Pocket Maximum, the Copayment or Coinsurance for this Service that is shown in the Benefit Summary remains in effect throughout the Calendar Year. 3.11.3 Understanding the Annual Limit on Cost-Sharing The Annual Limit on Cost-Sharing is the maximum out-of-pocket expense that a Member enrolled on a Family Plan must pay in a Calendar Year for In-Network Essential Health Benefit Covered Services. All In-Network Deductible, Copayment and Coinsurance amounts paid by the Member for Essential Health Benefit In-Network Covered Services apply to the Annual Limit on Cost-sharing. Once the Annual Limit on Cost-Sharing is met by a Member, the Plan will pay 100% for In-Network Essential Health Benefit Covered Services for that Member. An Annual Limit on Cost-Sharing is separate from an Out-of-Pocket Maximum, and can only be met by Member costs for In-Network Covered Services that qualify as Essential Health Benefits. Essential Health Benefits encompass 10 broad 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 dental and vision care.	Coinsurance and Deductible that a Member must pay in a Calendar Year, as shown in the Benefit Summary, before ~~we~~the Plan begins to pay 100% for Covered Services for that Member within that Calendar Year. • ***Family Out-of-Pocket Maximum:*** The Family Out-of-Pocket Maximum applies when two or more Family Members are enrolled in the Plan, and means the total amount of Copayments, Coinsurance and Deductible that a family must pay in a Calendar Year, as shown in the Benefit Summary, before ~~we~~the Plan begins to pay 100% for Covered Services for any enrolled Family Members. The Family Out-of-Pocket Maximum can be met by the combined expenses of enrolled Family Members. Once the Family Out-of-Pocket Maximum is met, we will begin to pay 100% for Covered Services for enrolled Family Members within that Calendar Year. • *Note*: Only Member expenses for Covered Services can be used to meet your Individual and Family Out-of-Pocket Maximums. ***Embedded Out-of-Pocket Maximums:*** • ***Individual Out-of-Pocket Maximum:*** An Individual Out-of-Pocket Maximum means the total amount of Copayments, Coinsurance and Deductible that the 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:*** The 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				

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			Not all Services covered under the Plan qualify as Essential Health Benefits. If a Service does not qualify, it will not accumulate to the Annual Limit on Cost-Sharing and will be labeled as such in your Benefit Summary. No costs for Covered Services received Out-of-Network apply to the Annual Limit on Cost-Sharing. Member costs applied to the Annual Limit on Cost-Sharing will also apply to the In-Network Out-of-Pocket Maximum. ***Your Costs that Do Not Apply to the Annual Limit on Cost-Sharing*: The following out-of-pocket costs do not apply towards the Annual Limit on Cost-Sharing:** • Services that do not qualify as Essential Health Benefits; • Services not covered by this Plan; • Services in excess of any maximum benefit limit; • • Deductibles, Copayments or Coinsurance amounts for Adult Vision; • Fees in excess of the Usual, Customary and Reasonable (UCR) charges; • Premiums and penalties; and • Any costs you must pay if you do not follow Providence Health Plan's Prior Authorization requirements.	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 3.5; • Services in excess of any maximum benefit limit; • Fees in excess of the Usual, Customary and Reasonable (UCR) charges; • Deductibles, Copayments or Coinsurance amounts for Adult Vision; • Deductibles, Copayments or Coinsurance amounts 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 Covered Services are NOT eligible for 100% benefit coverage. If a Covered Service is indicated as not apply toward the Out-of-Pocket Maximum, the Copayment or Coinsurance for this Service that is shown in the Benefit Summary, remains in effect throughout the Calendar Year. 3.11.3 Understanding the Annual Limit on Cost-Sharing ~~The Annual Limit on Cost-Sharing is the maximum out-of-pocket expense that a Member enrolled on a Family Plan must pay in a Calendar Year for In-Network Essential Health Benefit Covered Services.~~ ***The Annual Limit on Cost-Sharing and Plans with Embedded Out-of-Pocket Maximums:***				

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				On Plans with Embedded Out-of-Pocket Maximums, the In-Network Individual Out-of-Pocket Maximum serves as the Annual Limit on Cost-Sharing unless the Out-of-Pocket Maximum is less than the Annual Limit on Cost-Sharing. ***The Annual Limit on Cost-Sharing and Plans with Aggregate Out-of-Pocket Maximums:*** On Plans with Aggregate Out-of-Pocket Maximums, the Annual Limit on Cost-Sharing is the maximum Out-of-Pocket expense that a Member enrolled on a Family Plan must pay in a Calendar Year for In-Network Essential Health Benefit Covered Services unless the Out-of-Pocket Maximum is less than the Annual Limit on Cost-Sharing. All In-Network Deductible, Copayment and Coinsurance amounts paid by the Member for Essential Health Benefit In-Network Covered Services apply to the Annual Limit on Cost-sharing. Once the Annual Limit on Cost-Sharing is met by a Member, the Plan will pay 100% for In-Network Essential Health Benefit Covered Services for that Member. An Annual Limit on Cost-Sharing is separate from an Out-of-Pocket Maximum, and can only be met by Member costs for In-Network Covered Services that qualify as Essential Health Benefits. Essential Health Benefits encompass 10 broad 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				

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				• Pediatric services, including dental and vision care. Not all Services covered under the Plan qualify as Essential Health Benefits. If a Service does not qualify, it will not accumulate to the Annual Limit on Cost-Sharing and will be labeled as such in your Benefit Summary. No costs for Covered Services received Out-of-Network apply to the Annual Limit on Cost-Sharing. Member costs applied to the Annual Limit on Cost-Sharing will also apply to the In-Network Out-of-Pocket Maximum. ***Your Costs that Do Not Apply to the Annual Limit on Cost-Sharing*: The following out-of-pocket costs do not apply towards the Annual Limit on Cost-Sharing:** • Services that do not qualify as Essential Health Benefits; • Services not covered by this Plan; • Services in excess of any maximum benefit limit; • Deductibles, Copayments or Coinsurance amounts for Adult Vision; • Fees in excess of the Usual, Customary and Reasonable (UCR) charges; • Premiums and penalties; and Any costs you must pay if you do not follow Providence Health Plan's Prior Authorization requirements.				
Protections against surprise medical bills	All Handbooks	Adding section explaining balance billing/surprise billing and member rights under the No Surprises Act	N/A	3.12 Understanding Protections Against Surprise Medical Bills When you get emergency care or get treated by an Out-of-Network Provider at an In-Network Hospital, Independent Freestanding Emergency Department or Ambulatory Surgical Center, you are protected by federal law from surprise billing or balance billing. **What is "balance billing" (sometimes called "surprise billing")?**	No	Yes, NSA	Language added to better communicate member rights under the No Surprises Act. This includes an explanation of balance billing, federally mandated protections for members in the event of surprise medical bills, and contact information to file a complaint. No change to member benefits.	

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				When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. "Out-of-Network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-Network Providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than In-Network costs for the same service and might not count toward your annual Out-of-Pocket Maximum. "Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care—like when you have an emergency or when you schedule a visit at an In-Network facility but are unexpectedly treated by an Out-of-Network Provider. **You are protected from balance billing for:** Emergency Services If you have an emergency medical condition and get Emergency Services from an Out-of-Network Provider or facility, the most the Provider or facility may bill you is your plan's In-Network cost-sharing amount (such as Deductibles, Copayments and Coinsurance). You cannot be balance billed for these Emergency Services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services. Certain services at an In-Network Hospital, Independent Freestanding Emergency Department or Ambulatory Surgical Center When you get services from an In-Network Hospital, Independent Freestanding Emergency Department or Ambulatory Surgical Center, certain Providers there may be Out-of-Network. In these cases, the most those Providers may bill you is your plan's In-Network				

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				cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These Providers cannot balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at these In-Network facilities, Out-of-Network Providers cannot balance bill you, unless you give written consent and give up your protections. You're never required to give up your protections from balance billing. You also aren't required to get care Out-of-Network. You can choose a Provider or facility in your plan's network. **When balance billing isn't allowed, you also have the following protections:** You are only responsible for paying your share of the cost (like the Copayments, Coinsurance, and Deductibles that you would pay if the provider or facility was In-Network). Your health plan will pay Out-of-Network Providers and facilities directly. Your health plan generally must: • Cover Emergency Services without requiring you to get approval for services in advance (Prior Authorization). • Cover Emergency Services by Out-of-Network Providers. • Base what you owe the Provider or facility (cost-sharing) on what it would pay an In Network Provider or facility and show that amount in your explanation of benefits. • Count any amount you pay for Emergency Services or Out-of-Network services toward your Deductible and Out-of-Pocket Maximum. If you believe you've been wrongly billed, you may contact Providence Health Plan Customer Service from 8:00 a.m. to 5:00 p.m. PST at 503-574-7500 or 1-800-888-8888, for hearing impaired call 711. You may also contact the U.S. Department of Health and Human Services and file a complaint by calling 800-985-3059				

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				(toll-free) or going to https://www.cms.gov/nosurprises/consumers.				
Emergency Services and Independent Freestanding Emergency Departments	All Handbooks	Clarifying language added in definitions of Emergency Medical Condition and Emergency Services	4.5.1 Emergency Care ********** **Definitions:** ***"Emergency Medical Condition"*** is a medical condition that manifests itself by acute symptoms of sufficient severity that a prudent layperson, possessing an average knowledge of health and medicine, would reasonably expect that failure to receive immediate medical attention would: • Result in serious impairment to bodily functions; • Result in serious dysfunction of any bodily organ or part; • Place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy; • With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which transfer may pose a threat to the health or safety of the woman or the unborn child; or • That is a behavioral health crisis. ***"Emergency Services"*** means, with respect to an Emergency Medical Condition: • An Emergency Medical Screening Exam or behavioral health assessment that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and • Such further medical examination and treatment as are required under the Emergency Medical Treatment and Active Labor Act (42 U.S.C. 1395dd) to stabilize a patient, to the extent the examination and treatment are within the capability of the staff	4.5.1 Emergency Care ********** **Definitions:** ***"Emergency Medical Condition"*** is a medical condition or behavioral health condition ~~that~~ manifesting ~~s~~ itself by acute symptoms of sufficient severity, including, but not limited to severe pain, that a prudent layperson, possessing an average knowledge of health and medicine, would reasonably expect that failure to receive immediate medical or behavioral health attention would: • Result in serious impairment to bodily functions; • Result in serious dysfunction of any bodily organ or part; • Place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy; • With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which transfer may pose a threat to the health or safety of the woman or the unborn child; or • That is a behavioral health crisis. ***"Emergency Services"*** means, with respect to an Emergency Medical Condition: • A~~n Emergency M~~medical ~~S~~screening ~~E~~exam or behavioral health assessment that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; ~~and~~ • Such further medical examination and treatment as are required under the Emergency Medical Treatment and Active	No	Yes, NSA	Language changes to more clearly comply with the No Surprises Act in defining what are considered Emergency Medical Conditions and Emergency Services. In addition, Independent Freestanding Emergency Departments are made distinct from Hospitals in the definitions. No changes to member benefit.	

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			and facilities available at the Hospital. ***"Emergency Medical Screening Exams"*** include medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition. Your Plan covers Emergency Services in the emergency room of any Hospital. **Emergency room Services are covered when your medical condition meets the guidelines for emergency care as stated above. Coverage includes Services to stabilize an Emergency Medical Condition and Emergency Medical Screening Exams.** If you or a Family Member believes that immediate assistance is needed for an Emergency Medical Condition**, call 911 or go to the nearest emergency room**. Tell the emergency personnel the name of your Primary Care Provider and show them your Member ID Card. Call your Primary Care Provider any time, any day of the week. Your Primary Care Provider or the provider-on-call will tell you what to do and where to go for the most appropriate care. Please be prepared to pay your Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are responsible for the Copayment/Coinsurance for each Hospital emergency room visit. If you are admitted to the Hospital from the emergency room, your emergency Services Copayment/Coinsurance does not apply and all Services are subject to the Inpatient Services benefit shown in your Benefit Summary. When you are admitted to an Out-of-Network Hospital from the emergency room, your Inpatient Services are covered under your In-Network benefit until your	Labor Act (42 U.S.C. 1395dd) to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at the Hospital or Independent Freestanding Emergency Department; and. • Covered Services provided by staff or facilities of a Hospital or Independent Freestanding Emergency Department after the Member is stabilized and as part of outpatient observation or an inpatient or outpatient stay, including post-stabilization services for medical or behavioral health conditions that is Medically Necessary to avoid placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. ~~***"Emergency Medical Screening Exams"*** include medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.~~ Your Plan covers Emergency Services in the emergency room of any Hospital or Independent Freestanding Emergency Department. ~~**Emergency room Services are covered when your medical condition meets the guidelines for emergency care as stated above. Coverage includes Services to stabilize an Emergency Medical Condition and Emergency Medical Screening Exams.**~~ If you or a Family Member believes that immediate assistance is needed for an Emergency Medical Condition**, call 911 or go to the nearest emergency room**. Tell the emergency personnel the name of your Primary Care Provider and show them your Member ID Card. Call your Primary Care Provider any time, any day of the week. Your Primary Care Provider or the provider-on-call				

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			condition becomes stable. Once your condition is stabilized, Providence Health Plan will work with you to arrange transfer to an In-Network facility. This process is called "repatriation." Costs for non-emergency medical transport to facilitate repatriation to an In-Network facility are covered in full. If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will be subject to your Out-of-Network benefits. **Note**: While Emergency Services received from Out-of-Network Providers at Out-of-Network Facilities are covered under your In-Patient benefit until the time that your condition becomes stable, the Out-of-Network Providers and Out-of-Network Facilities are not contracted with Providence Health Plan. Therefore, the claims are priced using Usual, Reasonable and Customary (UCR) pricing, as described in section 3.3. Unless otherwise prohibited by state or federal law, you may be billed by the Out-of-Network Providers and Out-of-Network Facilities for amounts above the Allowed Amount of the claim, as determined by UCR. The Plan does not pay for emergency room treatment for medical conditions that are not medical emergencies. Do not go to the emergency room for care that should take place in your provider's office. Routine care for sore throats, common colds, follow-up care, and prescription drug requests are not considered to be emergencies.	will tell you what to do and where to go for the most appropriate care. Please be prepared to pay your Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are responsible for the Copayment/Coinsurance for each Hospital emergency room visit. If you are admitted to the Hospital from the emergency room, your emergency Services Copayment/Coinsurance does not apply and all Services are subject to the Inpatient Services benefit shown in your Benefit Summary. When you are admitted to an Out-of-Network Hospital from the emergency room, your Inpatient Services are covered under your In-Network benefit until your condition becomes stable. Once your condition is stabilized, Providence Health Plan will work with you to arrange transfer to an In-Network facility. This process is called "repatriation." Costs for non-emergency medical transport to facilitate repatriation to an In-Network facility are covered in full. If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will be subject to your Out-of-Network benefits. ~~**Note**: While Emergency Services received from Out-of-Network Providers at Out-of-Network Facilities are covered under your In-Patient benefit until the time that your condition becomes stable, the Out-of-Network Providers and Out-of-Network Facilities are not contracted with Providence Health Plan. Therefore, the claims are priced using Usual, Reasonable and Customary (UCR) pricing, as described in section 3.3. Unless otherwise prohibited by state or federal law, you may be billed by the Out-of-Network Providers and Out-~~				

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				~~of Network Facilities for amounts above the Allowed Amount of the claim, as determined by UCR.~~ The Plan does not pay for emergency room treatment for medical conditions that are not medical emergencies. Do not go to the emergency room for care that should take place in your provider's office. Routine care for sore throats, common colds, follow-up care, and prescription drug requests are not considered to be emergencies.				
Injectable Meds at preferred site of care	All Handbooks	Clarifying language for the requirements of the Site of Care program.	**4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Osteopathic Manipulation, Dialysis, Infusion, Chemotherapy, Radiation Therapy, and Multidisciplinary Pain Management Programs** Benefits are provided, as shown in the Benefit Summary, and include Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, osteopathic manipulation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, radiation oncology, therapeutic procedures, and approved multidisciplinary pain management programs as ordered by your Qualified Practitioner. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. We may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, we will not Prior Authorize the Services. For additional information about Prior Authorization, see section 3.5. Covered Services under these benefits do not include Services for Outpatient Rehabilitative Services. See section 4.7.2 for those Services.	**4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Osteopathic Manipulation, Dialysis, Infusion, Chemotherapy, Radiation Therapy, and Multidisciplinary Pain Management Programs** Benefits are provided, as shown in the Benefit Summary, and include Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, osteopathic manipulation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, radiation oncology, therapeutic procedures, and approved multidisciplinary pain management programs as ordered by your Qualified Practitioner. Some injectable medication may be required to be supplied by a contracted Specialty Pharmacy or a preferred site of care, and some infused medications may need to be administered at a location not more than 15 miles from a member's home.~~be required to be supplied by a contracted Specialty Pharmacy~~ We may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, we will not Prior Authorize the Services. For additional information about Prior Authorization, see section 3.5.	No	No	Language clarification to explain requirements for the site of care program for injectable and infused medications.	

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				Covered Services under these benefits do not include Services for Outpatient Rehabilitative Services. See section 4.7.2 for those Services.				
Section 4.14.1 Using Your Prescription Drug Benefit	HSA Handbooks only	Removing bullet point, language no longer applies per federal mandates.	4.14.1 Using Your Prescription Drug Benefit Your prescription drug benefit requires that you fill your prescriptions at a Participating Pharmacy. ********** • The amount paid by a manufacturer discount and/or copay assistance programs will apply towards your Calendar Year Deductibles and Out-of-Pocket Maximums.	4.14.1 Using Your Prescription Drug Benefit Your prescription drug benefit requires that you fill your prescriptions at a Participating Pharmacy. ********** • ~~The amount paid by a manufacturer discount and/or copay assistance programs will apply towards your Calendar Year Deductibles and Out-of-Pocket Maximums.~~	No	Yes	Removing language advising of manufacturer discount/copay assistance program payments applying to Deductibles and Out of Pocket Maximums. Per IRS law, this is outdated and no longer enforced. No change to benefit.	
Section 7.2, Member Grievance & Appeal	All Handbooks	Updating Appeals & Grievances language per NCQA requirements	7.2.1 Your Grievance and Appeal Rights If you disagree with our decision about your medical bills or health care services, you have the right to an internal review. You may request a review if you have received an Adverse Benefit Determination. You may also file a quality of care or general complaint or Grievance with us. You may appoint an Authorized Representative to act on your behalf during your Grievance or Appeal. Please include as much information as possible including the date of the incident, the names of individuals involved, and the specific circumstances. In filing a Grievance or Appeal: • You can submit written comments, documents, records and other information relating to your Grievance or Appeal and we will consider that information in our review process. • You can, upon request and free of charge, have reasonable access to and copies of the documents, records and other information relevant to our decision, including the specific internal rule, guideline, protocol, or other similar criterion relied upon to make an Adverse Benefit Determination. • You can be represented by anyone of your choice at all levels of Appeal.	7.2.1 Your Grievance and Appeal Rights If you disagree with our decision about your medical bills or health care services, you have the right to an internal review. You may request a review if you have received an Adverse Benefit Determination. You may also file a quality of care or general complaint or Grievance with us. You may appoint an Authorized Representative to act on your behalf during your Grievance or Appeal. Please include as much information as possible including the date of the incident, the names of individuals involved, and the specific circumstances. In filing a Grievance or Appeal: • You can submit written comments, documents, records and other information relating to your Grievance or Appeal and we will consider that information in our review process. • ~~You can, upon request and free of charge, have reasonable access to and copies of the documents, records and other information relevant to our decision, including the specific internal rule, guideline, protocol, or other similar criterion relied upon to make an Adverse Benefit Determination.~~ • You can be represented by anyone of your choice at all levels of Appeal.	No	Yes, NCQA	Language clarification change per updated guidance provided by our NCQA consultant.	

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			Filing a Grievance or Appeal does not affect your right to receive benefits for Covered Services as otherwise provided under this Plan.	Request for Claim/Appeal File and Additional Information: • You can, upon request and free of charge, have reasonable access to and copies of the documents, records and other information relevant to our decision, at any time before, during or after the appeal process. This includes the specific internal rule, guideline, protocol, or other similar criterion relied upon to make an Adverse Benefit Determination, as well as a copy of your claim or appeal file as applicable. • You also have the right to request free of charge, at any time, the diagnosis and treatment codes and their meanings that are the subject of your claim or appeal. Filing a Grievance or Appeal does not affect your right to receive benefits for Covered Services as otherwise provided under this Plan.				
Section 7.2, Member Grievance & Appeal	All Handbooks	Updating to provide clarity on Grievance Appeal process.	**7. PROBLEM RESOLUTION** **** 7.2.2 Internal Grievance or Appeal You must file your internal Grievance or Appeal within 180 days of the date on our notice of the initial Adverse Benefit Determination, or that initial Determination will become final. Please advise us of any additional information that you want considered in the review process. If you are seeing an Out-of-Network Provider, you should contact the provider's office and arrange for the necessary records to be forwarded to Providence Health Plan for the review process. Your Grievance or Appeal will be reviewed by Providence Health Plan staff not involved in the initial determination. You may present your case in writing. Once a final determination is made, you will be sent a written explanation of the decision.	**7. PROBLEM RESOLUTION** **** 7.2.2 Internal Grievance or Appeal You must file your internal Grievance or Appeal within 180 days of the date on our notice of the initial Adverse Benefit Determination, or that initial Determination will become final. The 180-day timeframe applies to both Standard and Expedited appeals. Please ~~advise us of~~ provide us any additional information that you want us to consider ~~ed in the~~ during our review process. If you are seeing an Out-of-Network Provider, you should contact the provider's office and arrange for the necessary records to be forwarded to Providence Health Plan ~~for the review process~~. Your Grievance or Appeal will be reviewed by Providence Health Plan staff not involved in the initial determination. You may present your case in writing. Once a final determination	No	Yes, NCQA	Language clarification change per updated guidance provided by our NCQA consultant.	

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				is made, you will be sent a written explanation of the decision.				
Section 7.2, Member Grievance & Appeal	All Handbooks	Updating language for External Review process to clarify IRO makes eligibility decision rather than insurer or member.	7.2.3 External Review **If you are not satisfied with your internal Grievance or Appeal decision and your Appeal involves (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care or (e) an exception to a prescription drug formulary, you have the right to an external review by an Independent Review Organization (IRO).** Your request must be made in writing within 180 days of receipt of the internal Grievance or Appeal decision, or that internal decision will become final. If you agree, we may waive the requirement that you exhaust the internal review process before beginning the External Review process. We will notify the Oregon Division of Financial Regulation within two business days of receiving your request for external review, at which point an IRO will be assigned to the case by the Oregon Division of Financial Regulation and we will forward complete documentation regarding the case to the IRO. **If you request an external review you must agree to authorize release of medical records needed by the IRO and submit any additional information to the IRO no later than five days after the appointment of the IRO, or 24 hours in cases of expedited review.**The IRO is entirely independent of Providence Health Plan and performs its review under a contract with the Oregon Division of Financial Regulation. 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, (d) whether a course of treatment is delivered in an appropriate setting at an**	7.2.3 External Review **If you are not satisfied with your internal Grievance or Appeal decision ~~and your Appeal involves (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care or (e) an exception to a prescription drug formulary~~, you have the right to an external review by an Independent Review Organization (IRO).** The IRO will determine if your case qualifies for external review. To qualify for external review, the case must involve (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care or (e) an exception to a prescription drug formulary. Your request must be made in writing within 180 days of receipt of the internal Grievance or Appeal decision, or that internal decision will become final. If you agree, we may waive the requirement that you exhaust the internal review process before beginning the External Review process. We will notify the Oregon Division of Financial Regulation within two business days of receiving your request for external review, at which point an IRO will be assigned to the case by the Oregon Division of Financial Regulation and we will forward complete documentation regarding the case to the IRO. **If you request an external review you must agree to authorize release of medical records needed by the IRO and submit any additional information to the IRO no later than five days after the appointment of the IRO, or 24 hours in cases of expedited review.**The IRO is entirely independent of Providence Health Plan and performs its review under a contract with the Oregon Division of Financial Regulation. The IRO will notify you and us of its decision within three days for expedited	No	Yes, ORS 743B.256(1)(a) and OAR 836-053-1325(3) and ORS 743B.257	This change only applies to non-ERISA ASO governmental groups that are either required to or choose to follow state mandates. It is otherwise completely *optional* for traditional ERISA-subject ASO groups. Language clarification of member rights to External Review of Appeals and Grievance decisions per Oregon state mandates.	

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			appropriate level of care or (e) an exception to a prescription drug formulary. We pay for all costs for the handling of external review cases and we administer these provisions in accordance with the insurance laws and regulations of the state of Oregon. **If we do not comply with the IRO decision, we may be penalized by the Oregon Division of Financial Regulation, and you have the right to sue us under applicable Oregon law.**	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, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care or (e) an exception to a prescription drug formulary**~~**.** We pay for all costs for the handling of external review cases and we administer these provisions in accordance with the insurance laws and regulations of the state of Oregon. **If we do not comply with the IRO decision, we may be penalized by the Oregon Division of Financial Regulation, and you have the right to sue us under applicable Oregon law.**				
Adding Newly Divorced as SEP event	All Handbooks	Adding "divorce" under New Dependents section for Special Enrollment Periods	8.3.2 New Dependents If you were eligible to enroll as a Subscriber under this Plan, but did not enroll during a previous enrollment period, and a person becomes your Eligible Family Dependent through marriage, birth, adoption or placement for adoption, or foster care; we will provide a "special enrollment period" during which you and your Eligible Family Dependent(s) may enroll under this Plan.	8.3.2 New Dependents If you were eligible to enroll as a Subscriber under this Plan, but did not enroll during a previous enrollment period, and a person becomes your Eligible Family Dependent through marriage, divorce, birth, adoption or placement for adoption, or foster care; we will provide a "special enrollment period" during which you and your Eligible Family Dependent(s) may enroll under this Plan.	No	No	Language addition only, clarifying that divorce qualifies for Special Enrollment Period. No change to benefit.	
Information for ERISA Members	All Handbooks	Removing bullet that contains language that is no longer relevant or applicable	**11.2 INFORMATION FOR ERISA MEMBERS (PARTICIPANTS)** **** • **Continue group health plan coverage** ○ Continue health care coverage for yourself, Spouse or Dependents under the circumstances described in section 10.2 if, (a) there is a loss of coverage under the plan as a result of a qualifying event and, (b) your Employer has 20 or more employees. You or your Dependents may have to pay for such coverage. *(Please refer to section 10.2 for more information about COBRA.)*	**11.2 INFORMATION FOR ERISA MEMBERS (PARTICIPANTS)** **** • **Continue group health plan coverage** ○ Continue health care coverage for yourself, Spouse or Dependents under the circumstances described in section 10.2 if, (a) there is a loss of coverage under the plan as a result of a qualifying event and, (b) your Employer has 20 or more employees. You or your Dependents may have to pay for such coverage. *(Please refer to section 10.2 for more information about COBRA.)*	No	No	This change **only applies** to ASO groups with traditional ERISA-subject self-funded plans. It does **not** apply to any ASO groups with non-ERISA ASO governmental plans that are either required to or choose to follow state law. Removal of bulletpoint containing outdated or irrelevant information regarding COBRA coverage.	

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			○ Receive a reduction or elimination of exclusionary periods of coverage under your group health plan, if you have Creditable Coverage from another plan. You should be provided upon request a Certificate of Creditable Coverage, free of charge, when you lose coverage under your Employer's group plan, when you become entitled to elect COBRA continuation coverage (if applicable), when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.	○ ~~Receive a reduction or elimination of exclusionary periods of coverage under your group health plan, if you have Creditable Coverage from another plan. You should be provided upon request a Certificate of Creditable Coverage, free of charge, when you lose coverage under your Employer's group plan, when you become entitled to elect COBRA continuation coverage (if applicable), when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.~~				
Self-Administered Prescription Drug Definition	All Handbooks	Adding clarifying language for Self-Administered Prescription Drug Definition	**13.1 PRESCRIPTION DRUG SUPPLEMENTAL BENEFIT** The Prescription Drug Benefit provides coverage for prescription drugs which are Medically Necessary for the treatment of a covered illness or injury and which are dispensed by a Participating Pharmacy pursuant to a prescription ordered by a Qualified Practitioner for use on an outpatient basis, subject to your Plan's benefits, limitations and exclusions. **Prescription Drug Definition** The following are considered "Prescription Drugs:" 1. Any medicinal substance which bears the legend, "RX ONLY" or "Caution: federal law prohibits dispensing without a prescription;" 2. Insulin; 3. Any medicinal substance of which at least one ingredient is a federal legend drug in a therapeutic amount; and 4. Any medicinal substance which has been approved by the Oregon Health Evidence Review as effective for the treatment of a particular indication.	**13.1 PRESCRIPTION DRUG SUPPLEMENTAL BENEFIT** The Prescription Drug Benefit provides coverage for self-administered prescription drugs which are Medically Necessary for the treatment of a covered illness or injury and which are dispensed by a Participating Pharmacy pursuant to a prescription ordered by a Qualified Practitioner for use on an outpatient basis, subject to your Plan's benefits, limitations and exclusions. **Self-Administered Prescription Drug Definition** Self-Administered Prescription Drugs mean medicinal substances designated by the Pharmacy & Therapeutics Committee for self-administration and dispensed from a Participating Retail. Mail Order or Specialty Pharmacy and labeled for self-administration. The following are considered "Prescription Drugs:" 1. Any medicinal substance which bears the legend, "RX ONLY" or "Caution: federal law prohibits dispensing without a prescription;" 2. Insulin; 3. Any medicinal substance of which at least one ingredient is a federal legend drug in a therapeutic amount; and 4. Any medicinal substance which has been approved by the Oregon Health Evidence Review as effective for the treatment of a particular indication.	No	No	Adding clarifying language, including a more detailed definition, of Self-Administered Prescription Drugs to better communicate existing member benefit.	

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			********** **13.1.1 Using Your Prescription Drug Benefit** ********** • Self-administered chemotherapy drugs are covered under section 4.12.8 unless the benefits under this Prescription Drug Benefit allow for lower out-of-pocket costs to you. • Injectable medications received in your Provider's office are covered under section 4.3.5.	Prescription Drugs, including oral, topical and injectable medications delivered, injected or administered to you by a physician, other provider, or trained person in a Provider's office or other facility are not covered under your Prescription Drug Benefit. Prescription drugs administered in a Provider's office or other facility are subject to the applicable benefit. For example, Prescription Drugs delivered in a Provider's Office are subject to your Allergy Shots, Allergy Serums, Injectable and Infused Medications benefit. See section 4.3.5. Select self-administered injectable medications may allow for a 60-day transition period for a member to receive the drug at the provider's office, clinic, or facility. A list of these drugs, the Self-Administered Drug List, can be found on the Providence Pharmacy Resource website at ProvidenceHealthPlan.com/pharmacy. After this transition period, the member will need to self-administer at home and Your prescription drug benefit applies. ********** **13.1.1 Using Your Prescription Drug Benefit** ********** • ~~Self-administered chemotherapy drugs are covered under section 4.12.8 unless the benefits under this Prescription Drug Benefit allow for lower out-of-pocket costs to you.~~ • Select self-administered injectable medications are not covered when supplied in a provider's office, clinic or facility. Medications listed on the Self-Administered Drug list may be administered by a healthcare provider in a provider's office, clinic, or facility for a 60-day transition period, and benefits in section 4.3.5 apply. Please refer to the Providence Pharmacy Resource website at https://www.providencehealthplan.com/members/pharmacy-resources for the Self-Administered Drug list. After this transition period, you will need to self-administer at home and your prescription drug benefit applies.				

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				• Injectable medications received in your Provider's office are covered under section 4.3.5.				
Affordable Care Act Preventive Drugs definition	All Handbooks	Update to existing language defining ACA-covered preventive drugs	**13.1.4 Prescription Drugs** ********** **Affordable Care Act Preventive Drugs** Affordable Care Act (ACA) preventive drugs are medications, including contraceptives, which are listed in our formulary and are covered at no cost when received from Participating Pharmacies as required by the ACA. Over-the-counter ACA preventive drugs received from Participating Pharmacies will not be covered in full under the ACA preventive benefit without a written prescription from your Qualified Practitioner. Over-the-counter contraceptives do not require a written prescription, as required by ORS 743A.067(2(j)(C) or 743A.067(4).	**13.1.4 Prescription Drugs** ********** **Affordable Care Act Preventive Drugs** In accordance with the Affordable Care Act (ACA) your Plan covers, at no cost to you, certain preventive ~~drugs are~~ medications, including contraceptives, both prescription and Over-the-counter, when these medications are purchased from ~~which are listed in our formulary and are covered at no cost when received from~~ Participating Pharmacies.~~as required by the ACA~~. ACA preventive drugs your Plan covers are listed on your Formulary. Over-the-counter ACA preventive drugs received from Participating Pharmacies will not be covered in full under the ACA preventive benefit without a written prescription from your Qualified Practitioner. Over-the-counter contraceptives do not require a written prescription, as required by ORS 743A.067(2(j)(C) or 743A.067(4).	No	No	Language updated to better communicate member benefits under Affordable Care Act in regards to preventive medications.	
ACA Preventive Drugs Limitations	All Handbooks	Modifying language for ACA drug coverage limitation	13.1.7 Prescription Drug Limitations Prescription drug limitations are as follows: ********** 6. In accordance with the ACA, your Plan provides coverage in full of certain medications, including contraceptives, when these medications are purchased from Participating Pharmacies. Not all preventive medications are required to be covered in full by the ACA. Medications in this category may be subject to medical management techniques to determine frequency, method, treatment, or setting. Brand medications for which a generic is available will not be covered in full unless the Member has received Prior Authorization from Providence Health Plan. 7. Vacation supply overrides are limited to a 30-day supply once per Calendar Year. Additional exceptions may be granted on a case-by-case basis.	13.1.7 Prescription Drug Limitations Prescription drug limitations are as follows: ********** 6. In accordance with the Affordable Care Act (ACA) your Plan covers, at no cost to you, ~~provides coverage in full of~~ certain preventive medications, including contraceptives, both prescription and Over-the-counter, when these medications are purchased from Participating Pharmacies. Not all preventive medications are required to be covered in full ~~by the ACA~~ though. The ACA allows Plans to use reasonable medical management to select medications that are covered in full (for example, when there is a generic medication available, the brand name may not be covered in full). If your Provider does not feel that the medications covered in full by your Plan are the right ones for you, you may request coverage for a similar medication at $0 Cost-Share by	No	No	Language updated to better communicate member benefits under Affordable Care Act in regards to preventive medications.	

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				submitting a Prior Authorization. ~~Medications in this category may be subject to medical management techniques to determine frequency, method, treatment, or setting. Brand medications for which a generic is available will not be covered in full unless the Member has received Prior Authorization from Providence Health Plan.~~ Vacation supply overrides are limited to a 30-day supply once per Calendar Year. Additional exceptions may be granted on a case-by-case basis.				
Independent Freestanding Emergency Departments definition	All Handbooks	Added definition for "Independent Freestanding Emergency Department" as a distinct entity from Hospitals for Emergency Services.	N/A	**15. DEFINITIONS** The following are definitions of important terms used in this Plan and appear throughout as Capitalized text. ********** **Independent Freestanding Emergency Department** Independent Freestanding Emergency Department means a health care facility that provides Emergency Services and is geographically separate and distinct and licensed separately from a Hospital under applicable state law. See section 4.5.1.	No	Yes, NSA	Added definition to better communicate member rights under the No Surprises Act for Emergency Services taking place in this type of health care facility that may be separate from Hospitals. Language change only, no change to benefits..	
Medical Home Referral Definition change	All Choice and Connect Handbooks	Changing language of "Medical Home Referral" definition.	**Medical Home Referral** Medical Home Referral is a request through your Medical Home provider for Services. These Services must be medically necessary. Services must be for an In-Network Provider outside of your medical home. Members may need Prior Authorization.	**Medical Home Referral** ~~Medical Home Referral is a request through your Medical Home provider for Services. These Services must be medically necessary. Services must be for an In-Network Provider outside of your medical home. Members may need Prior Authorization.~~ All services received outside of your Medical Home will require a referral from your Medical Home Provider, with the exception of emergency and urgent care. Referrals are requested through your Medical Home provider. These Services must be medically necessary. Services must be for an In-Network Provider outside of your medical home. Some services may require Prior Authorization in addition to a referral.	No	Yes, NCQA	Language clarification change per updated guidance provided by our NCQA consultant.	

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				Services that require a referral may change. Contact customer service 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance or speak with your Medical Home provider if you have questions.				
Section 15 Service Area	Connect Handbooks	Updating Service Area to include additional zip code of Yamhill County	**15. SERVICE AREA** **** Service Areas include: All ZIP codes in the following Oregon counties: Clackamas Hood River Multnomah Washington Selected ZIP codes in the following Oregon counties: **Yamhill – 97132**	**15. SERVICE AREA** **** Service Areas include: All ZIP codes in the following Oregon counties: Clackamas Hood River Multnomah Washington Selected ZIP codes in the following Oregon counties: **Yamhill –97123, 97132**	Yes	No	Update made to increase Connect Network adequacy.	