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

Open Option, Personal Option

DRAFT –07/01/2022

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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 a certified examiner of the International Board of Lactation Consultant Examiners (IBLCE).	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	All Handbooks	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. Only your actual out-of-pocket payments will count toward your deductible or out-of-pocket maximum. Manufacturer-funded financial assistance will not be considered true out of pocket costs for plan participants and [may/will not] apply to out of pocket deductible maximums. 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. ************ 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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Adding Newly Divorced as SEP event	All Handbooks	Adding new section Newly Divorced under 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. ******** **8.3.3 Court Orders**	**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. ********** 8.3.3 Newly Divorced If you are currently enrolled as a Subscriber and you become newly divorced and your Employer offers more than one health benefit plan, we will provide a "special enrollment period" during which you and your Eligible Family Dependents may change your enrollment to another plan. The "special enrollment period" shall be 60 days beginning on the date your divorce became final. Coverage shall be effective the first day of the calendar month following our receipt of the enrollment request, or an earlier date as agreed to by us. **8.3.~~3~~4 Court Orders**	No	No	**Note:** Acceptance is *optional*, however, PHP recommends adoption to provide a better benefit for members.	☐ 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
Category B: Benefit Administration Changes – For all plan types, except as otherwise denoted								

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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.	
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.	

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Category C: Language Changes Only – For all plan types, except as otherwise denoted								
Maternity Services at Out of Network facilities	All Handbooks	Updating Covered Services to include Out-of-Network health care facilities due to ongoing state or federally declared public health emergency.	**4.8 MATERNITY 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** *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. ****	**4.8 MATERNITY 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. ****	No	Yes, HB 4134	Clarifying language only. No change to benefit or administration of benefit.	

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Online tools	All Handbooks	Adding clarifying language to Wellness information bullet.	2.7 WELLNESS BENEFITS Providence Health Plan Members have access to the following wellness benefits: *************** • Wellness information o You can find medical information, class information, information on extra values and discounts and other information by visiting providence.org/healthplans.	2.7 WELLNESS BENEFITS Providence Health Plan Members have access to the following wellness benefits: *************** • Wellness information 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.	No	No	Added language specifying member benefits available as part of the Wellness Benefits program.	
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")?** 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-	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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				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 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:				

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				• 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 (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.	**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	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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			"Emergency Services" means, with respect to an Emergency Medical Condition: • An Emergency Medical Screening Exam or behavioral health assessment that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and • Such further medical examination and treatment as are required under the Emergency Medical Treatment and Active Labor Act (42 U.S.C. 1395dd) to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at the Hospital. ***"Emergency Medical Screening Exams"*** include medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition. Your 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	• That is a behavioral health crisis. ***"Emergency Services"*** means, with respect to an Emergency Medical Condition: • An ~~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 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**~~				

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			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-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,	~~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 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.				

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			and prescription drug requests are not considered to be emergencies.	~~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.				
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.	**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	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.	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.				
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 is made, you will be sent a written explanation of the decision.	No	Yes, NCQA	Language clarification change per updated guidance provided by our NCQA consultant in order to meet 3 separate must-pass requirements for NCQA.	
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.)* ○ Receive a reduction or elimination of exclusionary periods of coverage under your group health plan, if you have Creditable	**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.)* ○ ~~Receive a reduction or elimination of exclusionary periods of coverage under your group health plan, if you have Creditable~~	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.	

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

Open Option, Personal Option

DRAFT –07/01/2022

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			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.	~~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. 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	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.	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. • Injectable medications received in your Provider's office are covered under section 4.3.5.				
Independent Freestanding Emergency Departments definition	All Handbooks	Added definition for "Independent Freestanding Emergency Department"	N/A	**15. DEFINITIONS** The following are definitions of important terms used in this Plan and appear throughout as Capitalized text. ********************	No	No	Added definition to clarify member benefits for Emergency Services apply to this type of health care facility that may be separate from Hospitals.	

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		as a distinct entity from Hospitals for Emergency Services.		**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.				
Important information about your plan	All Summaries	Add Preventive Flyer link to Important Information Section of Benefit Summaries	N/A	Learn more about covered preventive services rated "A" or "B" by the U.S. Preventive Services Task Force at http://www.ProvidenceHealthPlan.com/PreventiveCare	No	No	No benefit changes, business decision to add for member's edification	
Update to Virtual Visit language	All Summaries	In-Person or Virtually distinction added to alternative care provider info.	**Physician/Professional Services** **** Office visits to an Alternative Care Provider (such as naturopath)	**Physician/Professional Services** **** Office visits to an Alternative Care Provider [(in-person or virtually)] (such as naturopath)	No	No	Clarifying language only to distinguish between in-person and virtual visits for Alternative Care.	