0124 to 0125 ASO Contract Comparison – ACA grandfathered plans (GR)

Open Option, Personal Option

FINAL - 9/18/2024

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Topic	Affected Material	Description	Current Language & Provisions (from existing 0124 documents)	New Language & Provisions (in new 0125 documents)	Benefit or Benefit Administ-ration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
Category A: Optional Benefit Changes – For all plan types, except as otherwise denoted								
Section 4.9.2 Medical Appliances	All handbooks	Remove limit for custom shoe orthotics	**4.9.2 Medical Appliances** *********** 4. Removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are subject to the benefit maximum stated in the Benefit Summary, and do not apply to your Deductible.	**4.9.2 Medical Appliances** *********** 4. Removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes.	Yes	Yes, OR SB 797	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. KJG Comments: Removal of this limit will align with FI plans following OR state laws.	☒ Yes ☐ No
Medical Equipment, Supplies and Devices	All Benefit Summaries	Remove custom shoe orthotics limit	**Medical Equipment, Supplies and Devices** **** Removable custom shoe orthotics (Limited to $200 per calendar year) ****	**Medical Equipment, Supplies and Devices** **** Removable custom shoe orthotics ****	Yes	Yes, OR SB 797	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. KJG Comments: Removal of this limit will align with FI plans following OR state laws. Same benefit as mentioned above, acceptance should align.	☒ Yes ☐ No
Introduction of new section: 8.3.2 Position Change + Subsequent section renumbering	All handbooks	Adding a change in job (such as promotion) qualifying event where a member is allowed a special enrollment period to add a dependent or make a change especially when there is a change in the employer contribution.	**8.3.1 Loss of Other Coverage** **** **8.3.2 New Dependents** ****	**8.3.1 Loss of Other Coverage** **** **8.3.2 Position Change** If you are currently enrolled as a Subscriber and you experience a change in employment status that results in a change in the individual's eligibility for coverage under the group health 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 30 days beginning on the date of your employment change. Coverage shall be effective the first day of the calendar month following our receipt of the enrollment request. **8.3.3 New Dependents** ****	Yes	No	**Note:** Acceptance is *optional*, however, PHP recommends adoption to provide a better benefit for members. KJG Comments: May want to discuss any internal eligibility administrative impacts to this change.	☐ Yes ☐ No

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				Please note: Subsequent 8.3 subsections are also renumbered.				
Using your prescription drug benefit	All benefit summaries	Adjusted insulin cost	**Using your prescription drug benefit:** **** • Insulin capped at [$0-500] for a 30-day supply or [$0-500] for a 90-day supply. [After deductible is met] [Deductible does not apply]. ****	**Using your prescription drug benefit:** **** • Insulin capped at [$0-35] for a 30-day supply or [$0-105] for a 90-day supply. [After deductible is met] [Deductible does not apply]. ****	Yes	2024 OR SB 1508	**Benefit Summary change only, no handbook changes.** 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. KJG Comments: Currently Clackamas County Plans follow the insulin cap ($85) this update to the SB lowers the cap to $35.	☒ Yes ☐ No

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Category B: Benefit Administration Changes – For all plan types, except as otherwise denoted								
Multiple sections	All handbooks	Establishing primary care provider selection requirements per state mandate.	1. INTRODUCTION ********* ➢ All Members are encouraged to choose a Primary Care Provider who will provide preventive and primary care Services and coordinate other care in a convenient and cost-effective manner. ***************** 3. HOW TO USE YOUR PLAN Our goal is maintaining your health by promoting wellness and preventive care. We encourage you to work closely with one provider, your Primary Care Provider, who can provide most of your care, suggest specialist care and arrange for Hospital care or diagnostic testing. ******** 3.2 THE ROLE OF A PRIMARY CARE PROVIDER To encourage optimum health, we promote wellness and preventive care. We also believe wellness and overall health is enhanced by working closely with one physician or provider – your Primary Care Provider. Your Primary Care Provider can provide most of your care and, when necessary, coordinate care with other providers in a convenient and cost-effective manner. We recommend that upon joining Providence Health Plan you and each of your Family Members choose an In-Network Primary Care Provider as soon as possible. ********** 3.2.3 Selecting a New Primary Care Provider We recommend that you choose a Primary Care Provider from our Provider Directory, available online, for each covered Family Member. Call the provider's office to make sure he or she is accepting new patients. It is a good idea to have your previous physician or provider transfer your medical records to your new Primary Care Provider as soon as possible. The first time you make an appointment with your Primary Care Provider, let him or her know you are now	1. INTRODUCTION ********* ➢ Your plan requires assignment of a Primary Care Provider. If you do not select a Primary Care Provider within 90 days of coverage beginning, you will be assigned one in your area. ***************** 3. HOW TO USE YOUR PLAN Our goal is maintaining your health by promoting wellness and preventive care. This Plan requires assignment of a Primary Care Provider, who can provide most of your care, suggest specialist care and arrange for Hospital care or diagnostic testing. ******** 3.2 THE ROLE OF A PRIMARY CARE PROVIDER To encourage optimum health, we promote wellness and preventive care. We also believe wellness and overall health is enhanced by working closely with one physician or provider – your Primary Care Provider. Your Primary Care Provider can provide most of your care and, when necessary, coordinate care with other providers in a convenient and cost-effective manner. We recommend you and each of your Family Members choose the In-Network Primary Care Provider that is right for you within 90 days of joining Providence Health Plan. Otherwise, we will assign one based on your location. *********** 3.2.3 Selecting a New Primary Care Provider This Plan requires assignment of a Primary Care Provider. If you do not select a Primary Care Provider for you and each of your Family Members within 90 days of coverage beginning, you will be assigned one in your area. To select a new Primary Care Provider, call the provider's office to make sure he or she is accepting new patients. It is a good idea to have your previous physician or provider transfer your medical records to	Yes	OR SB1529	This change only applies to non-ERISA ASO governmental groups that are either required to or choose to follow state mandates. KJG Comments: Note, this change from SB1529 requires a PCP to be assigned to the member, and PHP will assign a PCP if the members does not choose one. There are no requirements to use the PCP as assigned or consequences for not doing so. This change will not be implemented for groups that do not follow OR State Mandates.	

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			a Providence Health Plan Member. On your first visit, make a list of questions or information you would like to discuss with your new Primary Care Provider, including the following: • What are the office hours? • How can I get medical advice after hours? • What do I do in an emergency?	your new Primary Care Provider as soon as possible. The first time you make an appointment with your Primary Care Provider, let him or her know you are now a Providence Health Plan Member. On your first visit, make a list of questions or information you would like to discuss with your new Primary Care Provider, including the following: • What are the office hours? • How can I get medical advice after hours? • What do I do in an emergency?				
Multiple sections: 4.5.4 Emergency Detoxification Services 4.10.1 Mental Health Services 4.10.2 Applied Behavior Analysis 4.10.3 Substance Use Disorder Services	All handbooks	OR handbook parity updates. Adding brackets for Oregon handbooks and benefit summaries in case the ability to use prior authorization or concurrent review for behavioral health outpatient services ends beginning in 2025.	**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 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, Providence Health Plan 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 Providence Health Plan. *********** **4.10.1 Mental Health Services** ****** Covered Services include diagnostic evaluation, individual and group therapy, inpatient hospitalization	**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 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, Providence Health Plan 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. *********** **4.10.1 Mental Health Services** ****** Covered Services include diagnostic evaluation, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services. [For	Yes	Based on Proposed Federal Mental health parity regulations, sections are bracketed for review for language changes once pending rules are finalized.		

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			as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services. All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services must be Prior Authorized. ************ **4.10.2 Applied Behavior Analysis** ****** • Prior Authorization is received by us; ************ **4.10.3 Substance Use Disorder Services** ****** Prior Authorization is required for all inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services. Treatments involving the use of methadone are a Covered Service only when such treatment is part of a medically-supervised treatment program that has been Prior Authorized. In an emergency situation, go directly to a Hospital emergency room. You do not need Prior Authorization for emergency treatment; however, Providence Health Plan must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue.	inpatient, residential, day, intensive outpatient, or partial hospitalization treatment services; Providence Health Plan must be notified as soon as reasonably possible following the onset of treatment for coverage to continue.] ************ **4.10.2 Applied Behavior Analysis** ****** • [Prior Authorization is received by us]; ************ **4.10.3 Substance Use Disorder Services** ****** [For inpatient, residential, day, intensive outpatient, or partial hospitalization treatment services; Providence Health Plan must be notified as soon as reasonably possible following the onset of treatment for coverage to continue.] Treatments involving the use of methadone are a Covered Service only when such treatment is part of a medically-supervised treatment program that has been Prior Authorized. In an emergency situation, go directly to a Hospital emergency room. [You do not need Prior Authorization for emergency treatment; however, Providence Health Plan must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue.]				
Category C: Language Changes Only – For all plan types, except as otherwise denoted								
Multiple sections: Section 1. Introduction	All handbooks	Adding note regarding network exceptions for Out-of-Network providers within	**1. INTRODUCTION** **** **➢ Certain Covered Services require an approved Prior Authorization, as stated in section 3.5.**	**1. INTRODUCTION** **** **➢ Certain Covered Services require an approved Prior Authorization, as stated in section 3.5.**	No	Yes, WAC 284170-200(5)	KJG Comments: language update only	

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Section 3.3 Services Provided by Out-of-Network Providers		reasonable proximity to members.	➢ Coverage limitations and exclusions apply to certain Services, as stated in sections 3, 4, 5 and the Benefit Summary. **** **3.3 Services Provided by Out-of-Network Providers** **** **Payment for Out-of-Network Physician/Provider Services (UCR)** **** Thus, you may incur significantly larger out-of-pocket costs, perhaps a multiple of what would have applied, if you use Out-of-Network Physicians or Providers.	➢ If there are no In-Network providers in your area, or if you require unique Medically Necessary skills or Services that are not available from any In-Network providers in your area, you may request a Prior Authorization to be seen by an Out-of-Network provider or facility at the cost of your In-Network benefit. Allowable charges are based on Usual, Customary, and Reasonable (UCR) rates. These Services may be subject to review for Medical Necessity. ➢ Coverage limitations and exclusions apply to certain Services, as stated in sections 3, 4, 5 and the Benefit Summary. ***** **3.3 Services Provided by Out-of-Network Providers** **** **Payment for Out-of-Network Physician/Provider Services (UCR)** **** Thus, you may incur significantly larger out-of-pocket costs, perhaps a multiple of what would have applied, if you use Out-of-Network Physicians or Providers. **Payment for Out-of-Network Provider Services with Network Access Exception** If there are no In-Network providers in your area, or if you require unique Medically Necessary skills or Services that are not available from any In-Network providers in your area, you may request a Prior Authorization to be seen by an Out-of-Network provider or facility at the cost of your In-Network benefit. Allowable charges are based on UCR rates. These Services may be subject to review for Medical Necessity.		*Note: While this is required by WA mandate, this language change is a business decision to align with existing administration.*		
Multiple Sections 3.2.1 Primary Care Providers	All handbooks	Redefining "Primary Care Provider"	**3.2.1 Primary Care Providers** A Primary Care Provider is a Qualified Practitioner who specializes in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a physician assistant, when providing Services under the supervision of a physician, who agrees to be responsible for the continuing medical care by serving as case manager. Members may choose and self-refer	**3.2.1 Primary Care Providers** A Primary Care Provider is a Qualified Practitioner who specializes in family practice, general practice, internal medicine, or pediatrics; a nurse practitioner; or a physician associate practicing in collaboration with a primary care physician. Members may choose and self-refer to a physician specializing in obstetrics or gynecology, a nurse practitioner, a certified nurse	No	No	*No change to benefit, language updates in response to SB 1529*	

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15. Definitions			to a physician specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Primary Care Provider. Primary Care Providers provide preventive care and health screenings, medical management of many chronic conditions, allergy shots, treatment of some breaks and sprains, and care for many major illnesses and nearly all minor illnesses and conditions. Many Primary Care Providers offer maternity care and minor outpatient surgery as well. **IMPORTANT NOTE:** In-Network Primary Care Providers have a special agreement with us to serve as a case manager for your care. This means not all of our In-Network Providers with the specialties listed above are In-Network Primary Care Providers. Please refer to the Provider Directory, available online, for a listing of designated In-Network Primary Care Providers or call your Customer Service team to request a hard copy. ********* 15. DEFINITIONS ***** Primary Care Provider Primary Care Provider means a Qualified Practitioner specializing in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; a certified nurse midwife; or a physician assistant, when providing services under the supervision of a physician; who agrees to be responsible for the Member's continuing medical care by serving as case manager. Members may choose a Qualified Practitioner specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider.	midwife, or a physician associate specializing in women's health care as their Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Primary Care Provider. Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Note: Not all Qualified Practitioners are Primary Care Providers. To obtain a listing of In-Network Primary Care Providers, please see the online Provider Directory or call Customer Service. ************ 15. DEFINITIONS ***** Primary Care Provider A Primary Care Provider is a Qualified Practitioner who specializes in family practice, general practice, internal medicine, or pediatrics; a nurse practitioner; or a physician associate practicing in collaboration with a primary care physician. Members may choose and self-refer to a physician specializing in obstetrics or gynecology, a nurse practitioner, a certified nurse midwife, or a physician associate specializing in women's health care as their Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Primary Care Provider. Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.				

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			(Note: Not all Qualified Practitioners are Primary Care Providers. To obtain a listing of In-Network Primary Care Providers, please see the online Provider Directory or call Customer Service.)	Note: Not all Qualified Practitioners are Primary Care Providers. To obtain a listing of In-Network Primary Care Providers, please see the online Provider Directory or call Customer Service.				
Multiple Sections 3.2.1 Primary Care Providers 4.2 Women's Preventive Health Care Services 4.3.3. E-mail Visits 4.8 Maternity Services 14. Definitions	All handbooks	Change all uses of "Physician Assistant" to "Physician Associate" in text of Oregon Materials.	**3.2.1 Primary Care Providers** A Primary Care Provider is a Qualified Practitioner who specializes in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a physician assistant, when providing services under the supervision of a physician, who agrees to be responsible for the continuing medical care by serving as case manager. Members may also choose and self-refer to a physician specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Primary Care Provider. ***************	**3.2.1 Primary Care Providers** A Primary Care Provider is a Qualified Practitioner who specializes in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a physician associate, when providing services under the supervision of a physician, who agrees to be responsible for the continuing medical care by serving as case manager. Members may also choose and self-refer to a physician specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician associate specializing in women's health care as their Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Primary Care Provider. *************** *Please note: Only one redlined change is indicated in this Contract Comparison, but the change is reflected throughout the entire handbook in the sections listed in the first column. Section names may differ slightly across documents.*	No	Yes, OR HB 4010	KJG Comments: Definition of a Physician Assistant updated to Physician Associate to better align with OR state language	
Multiple Sections 3.5 Prior Authorization 4.6 Inpatient Hospital and Skilled Nursing Facility Services	All handbooks	Mental health parity language updates. Clarification of language related to behavioral health. Adjusting language to be more in line with mental health parity and to correct errors in the type of	**3.5 Prior Authorization** **Failure to Obtain Prior Authorization:** If you do not obtain Prior Authorization for Services received from an Out-of-Network Provider, as specified in section 3.3, a 50% **penalty,** not to exceed $2,500 for each Covered Service, will be applied to the claim. Should Providence Health Plan determine that we would have covered the Service had Prior Authorization been obtained, benefits will be applied to the remaining claim balance after the Prior Authorization Penalty is assessed. The **penalty** does **NOT** apply to the Deductible, if any, or to the Out-of-Pocket Maximum shown in the Benefit Summary.	**3.5 Prior Authorization** **Failure to Obtain Prior Authorization:** If you do not obtain Prior Authorization for Services received from an Out-of-Network Provider, as specified in section 3.3, a 50% **penalty,** not to exceed $2,500 for each Covered Service, will be applied to the claim. Should Providence Health Plan determine that we would have covered the Service had Prior Authorization been obtained, benefits will be applied to the remaining claim balance after the Prior Authorization Penalty is assessed. The **penalty** does **NOT** apply to the Deductible, if any, or to the Out-of-Pocket Maximum shown in the Benefit Summary. The penalty also does	No	Mental health parity related but a clarification and does not stem from a direct regulation.	KJG Comments: Changes in Prior Auth language for mental health services to align with mental health parity CMS regulations and guidance that are set to be released in October. (Language may be edited slightly when regulations are released)	

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4.6.2 Skilled Nursing Facility 4.7.2 Outpatient Rehabilitative Services 4.10.2 Applied Behavior Analysis 4.10.3 Substance Use Disorder Services 4.11.1 Home Health Care 4.12.4 Reconstructive Surgery 4.12.5 Reconstructive Breast Surgery 4.12.6 Restoration of Head/Facial Structures; Limited Dental Services		authorizations required for some behavioral health and medical services.	**** **4.6 Inpatient Hospital and Skilled Nursing Facility Services** Coverage is provided, as shown in your Benefit Summary for Hospital and Skilled Nursing Facility Services. Covered Services do NOT include care received that consists primarily of: • Room and board and supervisory or custodial Services. • Personal hygiene and other forms of self-care. • Non-skilled care for senile deterioration, mental deficiency, or developmental disability. ***** **4.6.2 Skilled Nursing Facility** Benefits are provided, as shown in the Benefit Summary for Covered Services from a Skilled Nursing Facility. Services must be Prior Authorized by Providence Health Plan and prescribed by your Qualified Practitioner in order to limit hospital Confinement by providing convalescent skilled medical and nursing Services which cannot be adequately provided through a home health program. Benefits are subject to the durational limits stated in your Benefit Summary. ************** **4.7.2 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. Limits do not apply to Mental Health Covered Services.	NOT apply to Mental Health or Substance Use Disorder Services. **** **4.6 Inpatient Hospital and Skilled Nursing Facility Services** Coverage is provided, as shown in your Benefit Summary for Hospital and Skilled Nursing Facility Services. Providence Health Plan must be notified as soon as reasonably possible following the onset of treatment for coverage to continue. Covered Services do NOT include care received that consists primarily of: • Room and board and supervisory or custodial Services. • Personal hygiene and other forms of self-care. • ***** **4.6.2 Skilled Nursing Facility** Benefits are provided, as shown in the Benefit Summary for Covered Services from a Skilled Nursing Facility. Services must be prescribed by your Qualified Practitioner in order to limit hospital Confinement by providing convalescent skilled medical and nursing Services which cannot be adequately provided through a home health program. Benefits are subject to the durational limits stated in your Benefit Summary. ************** **4.7.2 Outpatient Rehabilitative Services** Benefits are included for outpatient physical, occupational and speech therapy, subject to the following limitations: • Services must be Medically Necessary; • Services must be provided by a physician or licensed/registered therapist, as stated in the Benefit Summary, to restore or improve lost function following illness or injury. • Prior Authorization must be received by Providence; and				

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4.12.10 Gender Dysphoria 5. Exclusions 13. Definitions			A visit is considered a treatment with one provider (e.g., if you see a physical therapist and a speech therapist the same day at the same facility, it counts as two visits as you have received treatment from two providers). 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. Covered Services under this benefit do **NOT** include: • Chiropractic adjustments and manipulations of any spinal or bodily area; • Exercise programs; • Rolfing, polarity therapy and similar therapies; and • Rehabilitation services provided under an authorized home health care plan, as stated in section 4.11. See section 4.6.3 for coverage of Inpatient Rehabilitative Services. *************** **4.10.2 Applied Behavior Analysis** Benefits are provided for Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorders, subject to the following limitations: • Services must be Medically Necessary; • The initial screening and an individualized treatment plan must be provided by a licensed neurologist, pediatric neurologist, developmental pediatrician, psychiatrist or psychologist, who has experience or training the diagnosis of autism spectrum disorder;	• 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. Limits do not apply to Mental Health Covered Services. A visit is considered a treatment with one provider (e.g., if you see a physical therapist and a speech therapist the same day at the same facility, it counts as two visits, as you have received treatment from two providers). 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. Exclusions to outpatient Services:: • Chiropractic adjustments and manipulations of any spinal or bodily area; • Exercise programs; • Rolfing, polarity therapy and similar therapies; and • Rehabilitation services provided under an authorized home health care plan, as stated in section 4.11. See section 4.6.3 for coverage of Inpatient Rehabilitative Services. *************** **4.10.2 Applied Behavior Analysis** Benefits are provided for Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorders, subject to the following limitations: • Services must be Medically Necessary; • The initial screening and an individualized treatment plan must be provided by a licensed				

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			• Prior Authorization is received by us; • Benefits include coverage of any other non-excluded Mental Health or medical services identified in the individualize treatment plan; • Treatment must be provided by a health care professional licensed to provide ABA Services; and • Treatment may be provided in the Member's home or in a licensed health care facility. Exclusions to ABA Services: • Services provided by a family or household member; • Services that are custodial in nature, or that constitute marital, family, or training services; • Services that are educational or correctional that are provided by a school or halfway house or received as part of an educational or training program; • Custodial or respite care, creative arts therapy, wilderness or adventure camps, social counseling, music therapy, chelation or hyperbaric chambers; • Services provided under an individual education plan in accordance with the Individuals with Disabilities Education Act; • Services provided through community or social programs; and • Services provided by the Department of Human Services or the Oregon Health Authority, other than employee benefit plans offered by the department and the authority. An approved ABA treatment plan is subject to review by us and may be modified or discontinued if review shows that the Member receiving treatment is not making measurable clinical progress toward the goals identified in the treatment plan. ********* **4.10.3 Substance Use Disorder Services** ****	neurologist, pediatric neurologist, developmental pediatrician, psychiatrist or psychologist, who has experience or training the diagnosis of autism spectrum disorder; • Prior Authorization is received by us; • Benefits include coverage of any other non-excluded Mental Health or medical services identified in the individualize treatment plan; • Treatment must be provided by a health care professional licensed to provide ABA Services; and • Treatment may be provided in the Member's home or in a licensed health care facility. An approved ABA treatment plan is subject to review by us and may be modified or discontinued if review shows that the Member receiving treatment is not making measurable clinical progress toward the goals identified in the treatment plan. Exclusions to ABA Services: • Services provided by a family or household member; • Services that are custodial in nature, or that constitute marital, family, or training services; • Services that are educational or correctional that are provided by a school or halfway house or received as part of an educational or training program; • Custodial or respite care, creative arts therapy, wilderness or adventure camps, social counseling, music therapy, chelation or hyperbaric chambers; • Services provided under an individual education plan in accordance with the Individuals with Disabilities Education Act; • Services provided through community or social programs; and • Services provided by the Department of Human Services or the Oregon Health Authority, other than employee benefit plans offered by the department and the authority. *********				

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			Treatments involving the use of methadone are a Covered Service only when such treatment is part of a medically-supervised treatment program that has been Prior Authorized. *********** **4.11.1 Home Health Care** **** Home health care benefits do **NOT** include: 1. Charges for mileage or travel time to and from your home; 2. Wage or shift differentials for Home Health Providers; 3. Charges for supervision of Home Health Providers; or 4. Services that consist principally of Custodial Care including, but not limited to, care for senile deterioration, mental deficiency, mental illness, developmental disability or care of a chronic or congenital condition on a long-term basis. ************ **4.12.4 Reconstructive Surgery** Reconstructive Surgery is covered for conditions resulting from congenital defects, developmental abnormalities, trauma, infection, tumors or disease. Reconstructive surgery may be performed to correct a functional impairment in which the special, normal or proper action of any body part or organ is damaged; when necessary because of accidental injury or to correct scars or defects from accidental injury; or when necessary to correct scars or defects to the head or neck resulting from covered surgery. Benefits are covered as those Services listed in the Benefit Summary based upon the type of Services received. For Restoration of Head or Facial Structures; Limited Dental Services, see section 4.12.6. ************* **4.12.5 Reconstructive Breast Surgery** **** If you have additional questions about your WHCRA benefits, please contact Customer Service. ****	**4.10.3 Substance Use Disorder Services** **** Common formulations of medications for medication-assisted treatment such as buprenorphine and naltrexone are a covered benefit when Medically Necessary. Benefits are provided as shown in the Benefit Summary. Treatments involving the use of methadone are a Covered Service only when such treatment is part of a medically-supervised treatment program that has been Prior Authorized. *********** **4.11.1 Home Health Care** **** Home health care benefits do **NOT** include: 1. Charges for mileage or travel time to and from your home; 2. Wage or shift differentials for Home Health Providers; or 3. Charges for supervision of Home Health Providers. ************ **4.12.4 Reconstructive Surgery** Reconstructive Surgery is covered for conditions resulting from congenital defects, developmental abnormalities, trauma, infection, tumors or disease. Reconstructive surgery may be performed to correct a functional impairment in which the special, normal or proper action of any body part or organ is damaged; when necessary because of accidental injury or to correct scars or defects from accidental injury; or when necessary to correct scars or defects to the head or neck resulting from covered surgery. Benefits are covered as those Services listed in the Benefit Summary based upon the type of Services received. For Restoration of Head or Facial Structures; Limited Dental Services, see section 4.12.6. This exclusion does not apply to Mental Health or Substance Use Disorders. ************* **4.12.5 Reconstructive Breast Surgery** ****				

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			4.12.6 Restoration of Head/Facial Structures; Limited Dental Services **** Exclusions that apply to Covered Services include: • Cosmetic Services; **** **4.12.10 Gender Dysphoria** Benefits are provided for gender affirming Services for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and select surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable Inpatient or Outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for more information on services requiring Prior Authorization. ************** **5. Exclusions** ***** General Exclusions: **We do not cover Services and supplies which:** **** • Are provided to yield primarily educational outcomes, except as otherwise covered under the Preventive Services benefit described in section 4.1. An outcome is "primarily educational" if the outcome's fundamental, first, or principal character is to provide you with enduring knowledge, skill, or competence through a process of repetitive positive reinforcement over an extended length of time. An outcome is "enduring" if long-lasting or permanent; *****	This exclusion does not apply to Mental Health or Substance Use Disorders. If you have additional questions about your WHCRA benefits, please contact Customer Service. **** **4.12.6 Restoration of Head/Facial Structures; Limited Dental Services** **** Exclusions that apply to Covered Services include: • Cosmetic Services not considered Medically Necessary; **** **4.12.10 Gender Dysphoria** Benefits are provided for gender affirming Services for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and select surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable Inpatient or Outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply to certain inpatient procedures. Please see section 3.5 for more information on services requiring Prior Authorization. ************** **5. Exclusions** ***** General Exclusions: **We do not cover Services and supplies which:** **** • Are provided to yield primarily educational outcomes, unless Medically Necessary or as otherwise covered under the Preventive Services benefit described in section 4.1. An outcome is "primarily educational" if the outcome's fundamental, first, or principal				

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			• Are provided in an institution that specializes in treatment of developmental disabilities, except as provided in section 4.10.2; ***** • Relate to any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member if such Member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony or misdemeanor punishable by up to a year's imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or medical condition (i.e., a physical or mental health condition); ***** **We do not cover:** **** • All Services and supplies related to the treatment of obesity or morbid obesity, except as provided in section 4.1.7 and when added to this Plan as a Supplemental Benefit in section 13.4; ***** • Cosmetic Services including supplies and drugs, except as approved by us and described in section 4; ***** • Services provided under a court order or as a condition of parole or probation or instead of incarceration which are not Medically Necessary; ***** • Speech therapy, physical therapy and occupational therapy services provided in connection with treatment of psychosocial speech delay, learning disorders, including	character is to provide you with enduring knowledge, skill, or competence through a process of repetitive positive reinforcement over an extended length of time. An outcome is "enduring" if long-lasting or permanent; ***** • Are provided in a facility that specializes in treatment of developmental disabilities, except as provided in section 4.10.2; ***** • Relate to any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member if such Member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony or misdemeanor punishable by up to a year's imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or medical condition (i.e., a physical or mental health condition). This exclusion does not apply to Mental Health or Substance Use Disorder Services; ***** **We do not cover:** **** • All Services and supplies related to the treatment of obesity or morbid obesity, except as provided in section 4.1 and 4.10.1 and when added to this Plan as a Supplemental Benefit in section 13.4; ***** • Cosmetic Services including supplies and drugs not considered Medically Necessary; ***** • Services provided under a court order or as a condition of parole or probation or instead of incarceration, unless Medically Necessary;				

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			intellectual disability and motor skill disorders, and educational speech delay including delayed language development (except as provided in sections 4.6.3 and 4.7.2); • Counseling related to family, marriage, sex and career including, but not limited to, counseling for adoption, custody, family planning or pregnancy, in the absence of a diagnosis from the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM); **** **Exclusions that apply to Reproductive Services:** • All services related to sexual disorders or dysfunctions regardless of gender or cause. This exclusion does not apply to Mental Health Covered Services; ************ **13. Definitions** **** **Mental Health** Mental Health means any mental disorder covered by diagnostic categories listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), such as, but not limited to, major depressive disorder, autism spectrum disorder, dissociative identity disorder, gender dysphoria, and Substance Use Disorder.	***** • Counseling related to family, marriage, sex and career including, but not limited to, counseling for adoption, custody, family planning or pregnancy, This exclusion does not apply to Mental Health or Substance Use Disorders; **** **Exclusions that apply to Reproductive Services:** • All services related to sexual disorders or dysfunctions regardless of gender or cause, except as provided in section 4.12.6. This exclusion does not apply to Mental Health Covered Services; ************ **13. Definitions** **** **Mental Health** Mental Health means any mental health disorder covered by diagnostic categories listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), such as, but not limited to, major depressive disorder, autism spectrum disorder, dissociative identity disorder, gender dysphoria, and Substance Use Disorder.				
Multiple sections: Section 4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Osteopathic Manipulation, Dialysis,	All handbooks	New section to be added to the handbook for services lacking an appropriate coding category for Systems Admin purposes.	**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 4.3.6 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	**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 4.3.6 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for invasive or non-invasive surgical procedure, outpatient cardiac rehabilitation,	No	No		

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Infusion, Chemotherapy, Radiation Therapy, and Multidisciplinary Pain Management Programs New section: 4.12.18 Other Medical Services and Devices			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. 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.	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. 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. ***************** **4.12.18 Other Medical Services and Devices** This Plan covers support for implantable and external medical devices that are vital to your well-being. Coverage for initial device setup, device training, and evaluation of device functionality is provided when performed by a Qualified Practitioner. This coverage is subject to your In-Network and Out-of-Network coinsurance, as shown in your Benefit Summary. Coverage includes, but is not limited to, cardiac rhythm management devices, eye tracking devices for amblyopia, and both speech and non-speech generating devices.				
Section 2.7 Wellness Benefits	All handbooks	Update Care Management description: The old write up is broad, only mentions nurses, doesn't include 503 number, contact information, hours of operation, etc.	**2.7 WELLNESS BENEFITS** ********* • Providence Care Management ◦ Members can receive information and assistance with healthcare navigation and managing chronic conditions from a Registered Nurse Care Manager. ◦ You can access by calling 800-662-1121 or emailing caremanagement@providence.org.	**2.7 WELLNESS BENEFITS** ********* • Providence Health Plan Care Management ◦ Access to highly skilled care teams who provide personalized education, navigation, and care coordination support for your health conditions, including asthma, cancer, diabetes, Mental Health, and more. ◦ Ready to get started? Call 503-574-7247 or 800-662-1121] (TTY: 711) Monday through Friday, 8 a.m. to 5 p.m. (PST) or email Care.Management@Providence.org. Learn more at ProvidenceHealthPlan.com/CareManagement.	No	No		

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Section 4.1 Preventive Services	All handbooks	Updating dead weblink	**4.1 PREVENTIVE SERVICES** Preventive Services are covered, as shown in the Benefit Summary. For Women's Preventive Health Care Services, see section 4.2. In accordance with the Patient Protection and Affordable Care Act of 2010 and related legislation, your Plan covers the following Services in full when received from In-Network Providers: • Services rated "A" or "B" by the U.S. Preventive Services Task Force, http://uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/; ****	**4.1 PREVENTIVE SERVICES** Preventive Services are covered, as shown in the Benefit Summary. For Women's Preventive Health Care Services, see section 4.2. In accordance with the Patient Protection and Affordable Care Act of 2010 and related legislation, your Plan covers the following Services in full when received from In-Network Providers: • Services rated "A" or "B" by the U.S. Preventive Services Task Force, https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations; ****	No	No		

0124 to 0125 ASO Contract Comparison – ACA grandfathered plans (GR)

Open Option, Personal Option

FINAL - 9/18/2024

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Section 4.2.4 Family Planning Services	All handbooks	There was a PY2024 WA filing objection with Opill's anticipated entrance to the market (projected Q1 2024): how carriers are implementing coverage, clearly communicating Opill's coverage to members, and instructions in plan documents on how members will receive reimbursement if they pay for the Opill OOP. As this objection came through a day short of the PY2024 WA filing approval, it was determined this language would be modified as of PY2025.	**4.2.4 Family Planning Services** Benefits include counseling, exams, and Services for voluntary family planning. **Services and supplies are covered as required by the Patient Protection and Affordable Care Act of 2010 and related legislation; and include, but are not limited to:** • Intrauterine device (IUD) insertion and removal; • Medical exams and consultation for family planning; • Depo-Provera to prevent pregnancy; • Diaphragm devices; • Removal of implantable contraceptives; and • Oral contraceptives (birth control pills) listed in our Formulary. FDA approved women's prescription contraceptives: up to 3-months initial dispensing, then up to 12-months subsequent dispensing at any Participating Pharmacy.	**4.2.4 Family Planning Services** Benefits include counseling, exams, and Services for voluntary family planning. **Services and supplies are covered as required by the Patient Protection and Affordable Care Act of 2010 and related legislation; and include, but are not limited to:** • Intrauterine device (IUD) insertion and removal; • Medical exams and consultation for family planning; • Depo-Provera to prevent pregnancy; • Diaphragm devices; • Removal of implantable contraceptives; • Oral contraceptives (birth control pills) listed in our Formulary. FDA approved women's prescription contraceptives: up to 3-months initial dispensing, then up to 12-months subsequent dispensing at any Participating Pharmacy; and • Over-the-counter contraceptive drugs, devices, and products approved by the federal Food and Drug Administration.	No	No		
Section 4.2.4 Family Planning Services	All handbooks	Reimbursement instructions for OTC contraceptives	**4.2.4 Family Planning Services** **** All Covered Services must be received from Qualified Practitioners and Facilities or purchased from Participating Pharmacies.	**4.2.4 Family Planning Services** **** All Covered Services must be received from Qualified Practitioners and Facilities or purchased from Participating Pharmacies.	No	No		

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			• In-Network: Services are covered in full. • Out-of-Network: Services are covered subject to the provisions of the applicable Out-of-Network benefit, e.g., IUDs and diaphragms are covered under your medical supply benefit. For coverage of tubal ligation, see Elective Sterilization, section 4.12.9.	• In-Network: Services are covered in full. • Out-of-Network: Services are covered subject to the provisions of the applicable Out-of-Network benefit, e.g., IUDs and diaphragms are covered under your medical supply benefit. If you self-pay (without insurance) for over-the-counter contraceptives, you can submit a request for reimbursement. Please visit ProvidenceHealthPlan.com/Members/Pharmacy-Resources for more information. For coverage of tubal ligation, see Elective Sterilization, section 4.12.9.				
Section 4.4.2 Sleep Study Services	All handbooks	Removing reference to benefit summary, as Sleep Study line was removed in 2019.	**4.4.2 Sleep Study Services** Benefits are as shown in the Benefit Summary and include coverage of Medically Necessary polysomnography (PSG). PSG is an overnight sleep test performed at home or in a sleep laboratory. The test is used to confirm a sleep disorder and to determine the appropriate treatment. Services must be Prior Authorized.	**4.4.2 Sleep Study Services** Benefits include coverage of Medically Necessary polysomnography (PSG). PSG is an overnight sleep test performed at home or in a sleep laboratory. The test is used to confirm a sleep disorder and to determine the appropriate treatment. Services must be Prior Authorized.	No	No		

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Section 4.8 Maternity Services	All handbooks	Care Management Maternity Write Up: The old write up does not reflect all of the services offered, does not list contact information, and contains potentially confusing language.	**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 [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.	**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 [providence.org/classes] for information on classes, specific dates, locations, registration and prices. Classes vary by geographic area. In addition, you can partner with Providence Health Plan Care Management from preconception to pregnancy. Licensed clinical caregivers provide support with high-risk pregnancies, fertility health services, postpartum and more. To learn more, call Care Management at [503-574-7247] or [800-662-1121] (TTY: [711]) [Monday through Friday, 8 a.m. to 5 p.m. (PST)] or email [Care.Management@Providence.org].	No	No		
Section 4.9.4 Durable Medical Equipment (DME)	All handbooks	Coverage of insulin pump devices is referenced but not explained in 4.9.1 (last sentence).	**4.9.4 Durable Medical Equipment (DME)** Benefits are provided for DME, as shown in the Benefit Summary. Covered Services may include Medically Necessary equipment such as a hospital bed, non-motorized wheelchair, ventilator, and similar equipment as approved by us.	**4.9.4 Durable Medical Equipment (DME)** Benefits are provided for DME, as shown in the Benefit Summary. Covered Services may include Medically Necessary equipment such as a hospital bed, non-motorized wheelchair, ventilator, insulin pump devices, and similar equipment as approved by us.	No	No		
Section 4.10.3 Substance Use Disorder Services	All handbooks	Added clarifying language for SUD medication (no prior authorization required, lost medication, expired prescription).	**4.10.3 Substance Use Disorder Services** **** Common formulations of medications for medication-assisted treatment such as buprenorphine and naltrexone are a covered benefit when Medically Necessary. Benefits are provided as shown in the Benefit Summary. Treatments involving the use of methadone are a Covered Service only when such treatment is part of a medically-supervised treatment program that has been Prior Authorized.	**4.10.3 Substance Use Disorder Services** **** Common formulations of medications for medication-assisted treatment such as buprenorphine and naltrexone are a covered benefit when Medically Necessary. Benefits are provided as shown in the Benefit Summary. Treatments involving the use of methadone are a Covered Service only when such treatment is part of a medically-supervised treatment program that has been Prior Authorized.	No	House Bill 4002		

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			In an emergency situation, go directly to a hospital emergency room. You do not need Prior Authorization for emergency treatment; however, we must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue.	Prior Authorization is not required for medications used to treat Substance Use Disorders, including opiate addiction and withdrawal. Additionally, if your Substance Use Disorder medication has been lost, stolen, or destroyed, you are entitled to up to three early refills of your medication. If you need a refill of your Substance Use Disorder medication and your prescription has expired in the last 12 months, you are entitled to one refill of your medication without a current prescription. In an emergency situation, go directly to a hospital emergency room. You do not need Prior Authorization for emergency treatment; however, we must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue.				
Section 5 Exclusions	All handbooks	Updated incorrect section reference in Exclusions section	**5. EXCLUSIONS** **** **Exclusions that apply to Foot Care Services:** • Routine foot care, such as removal of corns and calluses, except for Members with diabetes; and • Services for orthotics, insoles, arch supports, heel wedges, lifts and orthopedic shoes, except as described in section 4.9.2. ****	**5. EXCLUSIONS** **** **Exclusions that apply to Foot Care Services:** • Routine foot care, such as removal of corns and calluses, except for Members with diabetes; and • Services for orthotics, insoles, arch supports, heel wedges, lifts and orthopedic shoes, except as described in section 4.9.3. ****	No	No		

0124 to 0125 ASO Contract Comparison – ACA grandfathered plans (GR)

Open Option, Personal Option

FINAL - 9/18/2024

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Section 13.1 Prescription Drug Benefit	All handbooks	Provide increased understanding and clarity of how a prescription drug is defined.	**13.1 PRESCRIPTION DRUG SUPPLEMENTAL BENEFIT** **** 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 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. Any medicinal substance of which at least one ingredient is a federal legend drug in a therapeutic amount;; 3. Any medicinal substance that the Food and Drug Administration (FDA) reviews for safety and benefit. Products labeled "Not evaluated by the FDA" are excluded 4. Any compounded drug product prepared using pharmaceutical grade active ingredients, which are reviewed by the FDA for safety and benefit; 5. Insulin; and 6. Any medicinal substance which has been approved by Oregon's Health Evidence Review Commission (HERC) as effective for the treatment of a particular indication.	No	No		
Section 13.1.1 Using Your Prescription Drug Benefit	All handbooks	Language falls in another section already, so this is only removing duplicative language.	**13.1.1 Using Your Prescription Drug Benefit** ***** • If a generic equivalent exists or becomes available, or if the cost of a brand-name drug changes, the tier placement of the brand-name drug may change, may require Prior Authorization, or the brand-name drug may no longer be covered. Additionally, if you or your provider choose a brand-name drug when a generic is available, you will be required to pay for the difference in cost between the	**13.1.1 Using Your Prescription Drug Benefit** *****	No	No		

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			brand-name drug and the generic drug, and the difference in cost will not apply to your Calendar Year Deductibles and Out-of-Pocket Maximums.					
Section 13.1.3 Prescription Drug Formulary	All handbooks	Clarifying newly approved FDA drug coverage language to specify that a request for coverage and a medical necessity review are required for prior authorization.	**13.1.3 Prescription Drug Formulary** ****** Newly approved FDA drugs will be reviewed by the Oregon Region Pharmacy and Therapeutics Committee for safety and Medical Necessity within 12 months after the drug becomes available on the market. In the case of an urgent situation, we will authorize the use of a newly approved FDA drug during our review period so a Member does not go without Medically Necessary treatment.	**13.1.3 Prescription Drug Formulary** ****** Newly approved FDA drugs will be reviewed by the Oregon Region Pharmacy and Therapeutics Committee for safety and Medical Necessity within 12 months after the drug becomes available on the market. In the case of an urgent situation, , you may request coverage of a newly approved FDA drug through the Prior Authorization process during our review period.	No	No		
Section 13.1.4 Prescription Drugs	All handbooks	Clarifying language around MPD (Member Pay Difference) as well as circumstances around brands going generic.	**13.1.4 Prescription Drugs** ***** If you request a brand-name drug, or if your provider prescribes a brand-name drug when a generic is available, regardless of the reason or Medical Necessity, you will be responsible for the difference in cost between the brand-name and generic drug, in addition to the brand-name drug Copayment or Coinsurance indicated on the Benefit Summary. Your total cost, however, will never exceed the actual cost of the drug. The difference in cost between the brand-name and generic drug will not be applied toward your Out-of-Pocket Maximum, and you will continue to be responsible for the difference in cost after your Out-of-Pocket Maximum is met. If your brand-name drug is authorized through formulary exception and our formulary includes a generic equivalent, you will be responsible for the difference in cost between the brand-name and the generic drug and the difference in cost will apply toward your Calendar Year Deductible and Out-of-Pocket Maximum.	**13.1.4 Prescription Drugs** ***** If you request a brand-name drug, or if your provider prescribes a brand-name drug when a generic is available, regardless of the reason or Medical Necessity, you will be responsible for the difference in cost between the brand-name and generic drug, in addition to the brand-name drug Copayment or Coinsurance indicated on the Benefit Summary. Your total cost, however, will never exceed the actual cost of the drug. The difference in cost between the brand-name and generic drug will not be applied toward your Out-of-Pocket Maximum, and you will continue to be responsible for the difference in cost after your Out-of-Pocket Maximum is met. If a generic equivalent exists or becomes available, or if the cost of a brand-name drug changes, the tier placement of the brand-name drug may change or require a formulary exception (which is a form of Prior Authorization). The brand-name drug may also no longer be covered. If your brand-name drug is authorized through formulary exception and our formulary includes a generic equivalent, you will be	No	No		

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				responsible for the difference in cost between the brand-name and the generic drug and the difference in cost will apply toward your Calendar Year Deductible and Out-of-Pocket Maximum.				
Section 13.1.7 Prescription Drug Limitations	All handbooks	Clarify intent with compound prescription drug coverage and better align with Pharmacy policy language.	**4.15.7 Prescription Drug Limitations** Prescription drug limitations are as follows: ******* 5. Compound prescription drugs must contain at least one ingredient that is an FDA-approved prescription drug in a therapeutic amount, must meet our Medical Necessity criteria and must be purchased at a Participating Pharmacy. Compounded drugs from bulk powders that are not a component of an FDA-approved drug are not covered. Claims are subject to clinical review for Medical Necessity and are not guaranteed for payment.	**4.15.7 Prescription Drug Limitations** Prescription drug limitations are as follows: ******* 5. Compounded prescriptions are subject to clinical review for Medical Necessity and Plan and benefit limitations. They are not guaranteed for payment. Compound drugs prepared using pharmaceutical-grade active ingredients may be approved. The product must be prescribed in a therapeutic amount, must meet our Medical Necessity criteria, and must be purchased at a Participating Pharmacy. Products with the disclaimer that the drug/product has not been reviewed by the FDA will not be covered. Inactive ingredients (e.g., fillers) used in the compound of the product that have been deemed not safe and/or beneficial by the FDA will not be covered.	No	No		
Section 13.1.8 Prescription Drug Benefit Exclusions	All handbooks	Updating BE to align with coverage language in corresponding section (4.12.16, Fertility Preservation Services).	**13.1.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ****** 3. Drugs used for the treatment of fertility/infertility, except when used in the treatment of Fertility Preservation for oncological conditions as outlined in section 4.12.16;	**13.1.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ****** 3. Drugs used for the treatment of fertility/infertility, except when used in the treatment of Fertility Preservation for oncological conditions and sickle cell disease as outlined in section 4.12.16;	No	No		

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Section 13.1.8 Prescription Drug Benefit Exclusions	All handbooks	Update prescription drug benefit exclusions. Splitting up the weight loss & cosmetic benefit exclusion into two distinct exclusions. Pharmacy recommends making these distinct for clarity.	**13.1.8 Prescription Drug Benefit Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Benefit Exclusions are as follows: **** 15. Drugs used for weight loss or for cosmetic purposes; 16. Drug kits, unless the product is available solely as a kit. Kits typically contain a pre-packaged drug along with items associated with the administration of the drug (e.g., gloves, shampoo);	**13.1.8 Prescription Drug Benefit Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Benefit Exclusions are as follows: **** 15. Drugs used for cosmetic purposes; 16. Drugs used for weight loss; 17. Drug kits, unless the product is available solely as a kit. Kits typically contain a pre-packaged drug along with items associated with the administration of the drug (e.g., gloves, shampoo);	No	No		
Section 13.1.8 Prescription Drug Benefit Exclusions	All handbooks	Adding prescription drug benefit exclusion. Clarifying language around treatments for hair loss.	**13.1.8 Prescription Drug Exclusions** ******* 15. Drugs used for weight loss or for cosmetic purposes; 16. Drug kits, unless the product is available solely as a kit. Kits typically contain a pre-packaged drug along with items associated with the administration of the drug (e.g., gloves, shampoo);	**13.1.8 Prescription Drug Exclusions** ******* 15. Drugs used for cosmetic purposes; 16. Drugs used for weight loss; 17. Drugs used to treat hair loss; 18. Drug kits, unless the product is available solely as a kit. Kits typically contain a pre-packaged drug along with items associated with the administration of the drug (e.g., gloves, shampoo);	No	No		
Using your prescription drug benefit	All Benefit Summaries	Provide clarity around SADs (Self-Administered Drugs) coverage.	**Using your prescription drug benefit:** **** • Self-injectable medications are only covered when they are being self-administered and labeled by the FDA for self-administration; in some cases, a Prior Authorization may be required for the drug. Documentation of self-administration may also be required. Drugs labeled for self-administration that are being	**Using your prescription drug benefit:** **** Certain injectable medications are deemed as Self-Administered Drugs by Providence Health Plan and will not be covered when administered by your provider, unless Prior Authorization is approved. Drugs may be deemed as Self-Administered Drugs if they are labeled by the FDA for administration by a patient (or their caregiver). Injectable medications labeled by the FDA	No	No		

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			administered by a provider will fall to the Member's medical benefit. ****	for administration only by a healthcare provider will generally be covered by your medical benefit.****				
Explanation of terms and phrases	All Benefit Summaries	Outlining the three main categories of medications for completeness.	**Explanation of terms and phrases:** **** **Formulary** – A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer effective drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications. ****	**Explanation of terms and phrases:** **** **Formulary** – A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer effective drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes brand-name, generic, and specialty medications. ****	No	No		
Explanation of terms and phrases	All Benefit Summaries	Clarifying that a formulary exception is a form of Prior Authorization. Shifting language for will pay > will be covered for better member understanding (familiarity with verbiage).	**Explanation of terms and phrases:** **** **Non-Formulary Medication** – An FDA-approved drug, generic or brand-name, that is not included in the list of approved formulary medications. These prescriptions require a prior authorization by the health plan and, if approved, will pay at either the highest non-specialty or specialty cost sharing tier. ****	**Explanation of terms and phrases:** **** **Non-Formulary Medication** – An FDA-approved drug, generic or brand-name, that is not included in the list of approved formulary medications. These prescriptions require formulary exception (a form of Prior Authorization) by the health plan and, if approved, will be covered at either the highest non-specialty or specialty cost sharing tier. ****	No	No		