0123 to 0124 ASO Contract Comparison – ACA non-grandfathered plans (non-GR)

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

DRAFT – 8/30/2023

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Category A: Optional Benefit Changes – For all plan types, except as otherwise denoted								
Section 4.12.15 Fertility Preservation Services	All Handbooks	Updates Fertility Preservation to apply to Members with sickle cell disease as well.	4.12.16 Fertility Preservation Services The Plan covers Fertility Preservation for where treatment related to cancer conditions may cause irreversible infertility as recommended by evidence-based guidelines such as the National Comprehensive Cancer Network (NCCN).	4.12.16 Fertility Preservation Services The Plan covers Fertility Preservation for Members with sickle cell disease or where treatment related to cancer conditions may cause irreversible infertility, as recommended by evidence-based guidelines such as the National Comprehensive Cancer Network (NCCN).	Yes	No	**Note:** Acceptance is *optional*, however, PHP recommends adoption to provide a better benefit for members.	☐ Yes ☐ No
New section: 4.14 Gene and Adoptive Cellular Therapy	All Handbooks	Creates a separate travel benefit specifically for Gene Therapy and Adoptive Cellular Therapy.	N/A	4.15 GENE AND ADOPTIVE CELLULAR THERAPY Gene and Adoptive Cellular Therapies are techniques that replace or modify a person's genes or cells to treat or cure some cancers and genetic diseases. Coverage is provided for Gene and/or Adoptive Cellular Therapy for Medically Necessary infusion benefits. Services are subject to Prior Authorization. Coverage is also provided for travel expenses for Gene and Adoptive Cellular Therapy. These travel expenses are subject to a $7,500 per calendar year maximum for transportation, food, and lodging. Deductible applies before reimbursement on HSA plans. Food and lodging is subject to a $300 per diem. Per Diem expenses apply to the $7,500 per calendar year benefit maximum. ************* 14. DEFINITIONS ***** Gene and Adoptive Cellular Therapy Gene and Adoptive Cellular Therapies are techniques that replace or modify a person's genes or cells to treat or cure some cancers and genetic diseases.	Yes	No	**Note:** Acceptance is *optional*, however, PHP recommends adoption to provide a better benefit for members.	☐ Yes ☐ No

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First 3 PCP visits coverage	All Benefit Summaries	First 3 PCP visits covered at $5	Physician/Professional Services Office visits to a Primary Care Provider [(in-person or virtually)] [In-person] [Covered in full] [$5-$200] [5%-50%][✓] [Virtually] [Covered in full] [$5-$200] [5%-50%][✓]	Physician/Professional Services Office visits to a Primary Care Provider [(in-person or virtually)] [In-person] ~~[Covered in full] [$5-$200] [5%-50%][✓]~~ [First {1-3} Visits] [$5] [✓] [Then] [$5-$200] [5%-50%][✓] [Virtually] [Covered in full] [$5-$200] [5%-50%][✓]	Yes	Yes, OR SB 1529 (2022)	**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.	☒ Yes ☐ No
Hearing Aid Coverage	All Benefit Summaries	Adding new benefit for hearing aids	N/A	Hearing aid coverage • One per ear every 3 calendar years, for all ages.	Yes	Yes, WA EHSB 1222	**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.	☒ Yes ☐ No
Insulin cost share cap	Health Savings Account and Pharmacy Summaries Only	Prescription Drugs section, increase to insulin cost share cap for OR Prescription Drugs section, no change to insulin cost share cap for WA, $35 remains accurate.	**Prescription Drugs** (Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies) Safe Harbor drugs are exempt from the deductible, subject to the formulary and applicable tier cost share **(Insulin cost share capped at $80 for a 30 day supply, Deductible does not apply.)** ********************* **Prescription Drugs** (Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies) Safe Harbor drugs are exempt from the deductible, subject to the formulary and applicable tier cost share **(Insulin cost share capped at $35 for a 30-day supply. Deductible does not apply.)**	**Prescription Drugs** (Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies) Safe Harbor drugs are exempt from the deductible, subject to the formulary and applicable tier cost share **(Insulin cost share capped at $85~~80~~ for a 30 day supply, Deductible does not apply.)** ********************* **Prescription Drugs** (Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies) Safe Harbor drugs are exempt from the deductible, subject to the formulary and applicable tier cost share **(Insulin cost share capped at $35 for a 30-day supply. Deductible does not apply.)**	Yes	Yes, OR HB 2623 and OAR 836-053-0025 WA SB 5546	**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.	☒ Yes ☐ No

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Category B: Benefit Administration Changes – For all plan types, except as otherwise denoted								
Multiple Sections	Choice and Connect Handbooks Only	Removal of referral requirement in Choice and Connect plans.	1. INTRODUCTION ************* ➢ Coverage under this Large Group Plan is provided through: • Our Providence Choice Network of Medical Homes and In-Network Providers; • Our local and national In-Network Providers; • Out-of-Network Providers; and • For Qualified Out-of-Area Dependents, our Signature Network with no Medical Home requirement. ➢ Members will generally have lower out-of-pocket expenses when obtaining Covered Services through your Medical Home. Members may, however, obtain most Covered Services from Out-of-Network Providers, but that option will result in higher out-of-pocket expenses. Please see section 4 and your Benefit Summary for additional information. ***** ➢ Coverage is provided in full for most preventive Services when those Services are received from your Medical Home. See your Benefit Summary for additional information. ➢ All Members are encouraged to choose a Medical Home Primary Care Provider who will provide preventive and primary care Services and coordinate other care in a convenient and cost-effective manner. ➢ **For In-Network Services that are outside of the Medical Home, a referral is needed. You must obtain a referral from your Medical Home before you receive the Services.** ************* 2.1 YOUR CHOICE PLAN Your Choice Plan allows you to receive Covered Services from your Medical Home. These Services are received through your In-Network benefit. Your plan also provides coverage for Services to other In-Network Providers. You may access these providers through a Medical Home Referral. A woman can directly access a	1. INTRODUCTION ************* ➢ Coverage under this Large Group Plan is provided through: ➢ Our Providence Choice Network of Medical Homes and In-Network Providers; ➢ Our local and national In-Network Providers; ➢ Out-of-Network Providers; and ➢ For Qualified Out-of-Area Dependents, our Signature Network with no Medical Home requirement. ➢ Members must choose a Medical Home as soon as possible. If you do not select a Medical Home within 30 days of your coverage beginning, you will be assigned one in your area. ➢ All Members are encouraged to choose a Medical Home Primary Care Provider who will provide preventive and primary care Services and coordinate other care in a convenient and cost-effective manner. ➢ Members will generally have lower out-of-pocket expenses when obtaining Covered Services through your Medical Home. Members may, however, obtain most Covered Services from Out-of-Network Providers, but that option will result in higher out-of-pocket expenses. Please see section 4 and your Benefit Summary for additional information. ***** ➢ Coverage is provided in full for most preventive Services when those Services are received from your Medical Home. See your Benefit Summary for additional information. ~~➢ All Members are encouraged to choose a Medical Home Primary Care Provider who will provide preventive and primary care Services and coordinate other care in a convenient and cost-effective manner.~~ ~~➢ For In-Network Services that are outside of the Medical Home, a referral is needed. You must obtain a referral from your Medical Home before you receive the Services.~~ *************	Yes	No	Moved from Benefit Changes to Benefit Admin Changes.	

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			Women's Health Care Provider without a referral from her designated Medical Home. **IMPORTANT NOTE: A Medical Home referral can get you better coverage. It is required to receive In-Network benefits outside of your Medical Home. The provider must also be In-Network.** You also may receive Covered Services without a referral or from Out-of-Network Providers. This applies to your Out-of-Network benefit. Generally, your out-of-pocket costs will be less when you receive Covered Services from your Medical Home and when your care is coordinated through your Medical Home. Your Medical Home will work with Providence Health Plan. They will arrange referrals and Prior Authorizations that may be needed for certain Covered Services. Prior Authorization and referrals are needed before treatment. More information is in section 3.5. ************* 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 Medical Home is your Primary Care Provider. They can provide most of your care and provide referrals to specialists. They can also arrange for Hospital care or diagnostic testing. ************* 3.1.1 Choosing or Changing a Medical Home Upon joining this Plan, you and each of your enrolled Family Members must choose a Medical Home as soon as possible. There are many Medical Homes to choose from. You and your covered Dependents may choose the same or different Medical Homes, depending on your preferences and needs.	2.1 YOUR CHOICE PLAN Your Choice Plan allows you to receive Covered Services from your Medical Home. These Services are received through your In-Network benefit. Your plan also provides coverage for Services from other In-Network and Out-of-Network Providers. Your Primary Care Provider must be inside your Medical Home or Services will be billed as Out-of-Network. See sections 3.1–3.3 for details about Medical Homes. A woman may choose to access an In-Network Women's Health Care Provider not in her Medical Home.~~Your plan also provides coverage for Services to other In-Network Providers. You may access these providers through a Medical Home Referral. A woman can directly access a Women's Health Care Provider without a referral from her designated Medical Home.~~ ~~IMPORTANT NOTE: A Medical Home referral can get you better coverage. It is required to receive In-Network benefits outside of your Medical Home. The provider must also be In-Network.~~ You also may receive Covered Services outside your Medical Home or ~~without a referral or~~ from Out-of-Network Providers. This applies to your Out-of-Network benefit. Generally, your out-of-pocket costs will be less when you receive Covered Services from your Medical Home and when your care is coordinated through your Medical Home. Your Medical Home will work with Providence Health Plan. They will arrange ~~referrals and~~ Prior Authorizations that may be needed for certain Covered Services. Prior Authorization may be~~and referrals are~~ needed before treatment. More information is in section 3.5. .... 3. HOW TO USE YOUR PLAN Our goal is maintaining your health by promoting wellness and preventive care. We encourage you to				

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			Once you have chosen a Medical Home, you must communicate your Medical Home selection to Providence Health Plan before receiving services: ***** *Adults age 18 and over must log into myProvidence separately to select their own medical homes. If you decide to change your Medical Home selection for yourself or any of your Enrolled Family Members during the Plan year, you must communicate such change in your Medical Home selection to Providence Health Plan by using any of the notification methods listed above. **If you do not communicate your selection or change in selection to Providence Health Plan before seeking services, your costs for care will be paid according to the Out-of-Network benefits.** <u>Advantages of Using a Medical Home</u> • Your Medical Home will work with Providence Health Plan. They will arrange any referral requirements that may be needed for certain Covered Services. More information is in section 3.5. • In most cases when you use your Medical Home, higher benefit levels will apply and your out-of-pocket expenses will be reduced. • **Your Medical Home will coordinate care, when necessary, with a wide variety of high quality In-Network Providers to help you with your health care needs.** **So remember, it is** to your advantage to meet your health care needs by using your Medical Home whenever possible. ************* 3.2.1 Medical Home Primary Care Providers A Medical Home 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	work closely with one provider. Your Medical Home is your Primary Care Provider. They can provide most of your care and ~~provide referrals to specialists. They can also~~ arrange for Hospital care or diagnostic testing. ************* 3.1.1 Choosing or Changing a Medical Home Upon joining this Plan, you and each of your enrolled Family Members must choose a Medical Home as soon as possible. There are many Medical Homes to choose from. You and your covered Dependents may choose the same or different Medical Homes, depending on your preferences and needs. <u>If you do not select a Medical Home within 30 days of your coverage beginning, you will be assigned one in your area.</u> Once you have chosen a Medical Home, you must communicate your Medical Home selection to Providence Health Plan before receiving services: ***** *Adults age 18 and over must log into myProvidence separately to select their own ~~m~~<u>M</u>edical ~~h~~<u>H</u>ome~~s~~. <u>Your Primary Care Provider must be inside your Medical Home or those Services will be billed as Out-of-Network.</u> If you decide to change your Medical Home selection for yourself or any of your Enrolled Family Members during the Plan year, you must <u>communicate the change to Providence Health Plan before seeking Services from the new Medical Home. You can notify us of the change using any of the notification methods listed above.</u>~~communicate such change in your Medical Home selection to Providence Health Plan by using any of the notification methods listed above.~~ **If you do not communicate your selection or change in selection to Providence Health Plan before seeking services, your costs for care will be paid according to the Out-of-Network benefits.** <u>Advantages of Using a Medical Home</u>				

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			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 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 Medical Home Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Medical Home Primary Care Provider. ************* 3.2.4 Office Visits ***** Specialists Your Medical Home Primary Care Provider will discuss with you the need for diagnostic tests. They may also discuss with you the need for other specialist services. also If necessary, they will refer you to an In-Network specialist for treatment. Your Medical Home will then coordinate your care. This may include sharing important information with your specialist. You must get a referral to receive covered services from a specialist. ************* 3.3 SERVICES PROVIDED WITHOUT MEDICAL HOME REFERRAL OR BY OUT-OF-NETWORK PROVIDERS Covered Services may be received without a Medical Home Referral. They may also be received Out-of-Network. Services would need to be from a qualified health care professional or facility. They would use your Out-of-Network benefit. See section 3.5 for Prior Authorization details. If you see a provider without a Medical Home Referral. Covered Services will be subject to your Out-of-Network benefits. These benefits are shown in the Benefit Summary. Even if the provider is listed as an In-Network Provider in our Provider Directory. Benefits for Covered Services by an Out-of-Network Provider will be provided, as shown in the Benefit Summary.	➢ ~~Your Medical Home will work with Providence Health Plan. They will arrange any referral requirements that may be needed for certain Covered Services. More information is in section 3.5.~~ ➢ In most cases when you use your Medical Home, higher benefit levels will apply and your out-of-pocket expenses will be reduced. ➢ Your Medical Home provides comprehensive primary care and will coordinate care, when necessary, with a wide variety of high quality In-Network Providers to help you with your health care needs. ➢ Your Medical Home will coordinate preventive health screenings and test results, ensuring your entire care team has the information they need to support your treatment plan. So remember, it is to your advantage to meet your health care needs by using your Medical Home whenever possible. ************* 3.2.1 Medical Home Primary Care Providers A Medical Home 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 an In-Network Women's Health Care Provider, including a physician specializing in obstetrics or gynecology, gynecologist, or midwife. ~~may 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 Medical Home Primary Care Provider.~~ Child Members may choose a physician specializing in pediatrics as their Medical Home Primary Care Provider. ************* 3.2.4 Office Visits *****				

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			When you receive Services without a Medical Home Referral or from an Out-of-Network Provider, your Copayments and Coinsurance will be higher. Costs for Covered Services will be higher than when you see your Medical Home Provider or have a Medical Home Referral to see an In-Network Provider. ************* 3.5 PRIOR AUTHORIZATION ***** Services received from Medical Homes or with a Medical Home Referral: Some Services from a Medical Home need Prior Authorization. The Provider must obtain this. This is true for Services completed from an In-Network Provider through a medical Home Referral as well. Services received without Medical Home Referral or from Out-of-Network Providers: You must submit Prior Authorization if you do not have a referral. To receive Prior Authorization contact Providence Health Plan. The Out-of-Network Provider may also contact Providence Health Plan. Further details can be found in section 3.3. ***** Failure to Obtain Prior Authorization: If you do not obtain Prior Authorization for Services received from an Out-of-Network Provider or without a Medical Home Referral, as specified in section 3.3, claims for those services will be denied and you will be responsible to pay those claims. ************* 3.12.2 Qualified Out-of-Area Dependent Coverage To be eligible for Qualified Out-of-Area Dependent coverage, you must apply to enroll. You must request permission. This will be done through Providence Health Plan. Eligibility is based on your home address. Students living Out-of-Area will use your school address to determine eligibility. A Dependent approved for Qualified Out-of-Area benefits may receive services In-Network. Only from Signature Network providers. Services can also be received Out-of-Network from Qualified Practitioners. Referrals are not required.	Specialists Your Medical Home Primary Care Provider will discuss with you the need for diagnostic tests. They may also discuss with you the need for other specialist services. also If necessary, they will refer you to an In-Network specialist for treatment. Your Medical Home will then coordinate your care with any Prior Authorization needed. ~~This may include sharing important information with your specialist. You must get a referral to receive covered services from a specialist.~~ ************* 3.3 SERVICES PROVIDED ~~WITHOUT MEDICAL HOME REFERRAL OR~~ BY OUT-OF-NETWORK PROVIDERS Covered Services may be received ~~without a Medical Home Referral. They may also be received~~ Out-of-Network. Services would need to be from a qualified health care professional or facility. They would use your Out-of-Network benefit. See section 3.5 for Prior Authorization details. ~~If you see a provider without a Medical Home Referral. Covered Services will be subject to your Out-of-Network benefits. These benefits are shown in the Benefit Summary. Even if the provider is listed as an In-Network Provider in our Provider Directory.~~ Benefits for Covered Services by an Out-of-Network Provider will be provided, as shown in the Benefit Summary. When you receive Services ~~without a Medical Home Referral or~~ from an Out-of-Network Provider, your Copayments and Coinsurance will be higher. Costs for Covered Services will be higher than when you see your Medical Home Provider or ~~have a Medical Home Referral to~~ see an In-Network Provider. ************* 3.5 PRIOR AUTHORIZATION *****				

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			Please refer to your Out-of-Area Dependent Benefit Summary. Details on Coinsurance or Copayment and annual Out-of-Pocket Maximum are found in this summary. ************* 4.2 WOMEN'S PREVENTIVE HEALTH CARE SERVICES Women may choose to receive Women's Preventive Health Care Services from a Primary Care Provider or a Women's Health Care Provider without a referral. Women's Health Care Providers include physicians specializing in obstetrics, some Primary Care Providers and naturopaths (if they are licensed to provide the Services), physician assistants and nurse practitioners specializing in women's health care, certified nurse midwives and licensed direct entry midwives. ************* 4.6.1 Inpatient Hospital Services Benefits are provided, as shown in your Benefit Summary. In-Network Benefit: When your In-Network Provider and Providence Health Plan determine you need hospitalization, arrangements will be made for you to be admitted to an In-Network Hospital. Out-of-Network Benefit: It is your responsibility to make sure that inpatient hospitalization services are Prior Authorized. Prior Authorization must come from Providence Health Plan. Once approved, care can be received from an Out-of-Network Hospital. A Medical Home Referral will not be needed for those Services. ************* 14. DEFINITIONS ***** <u>In-Network</u> In-Network covered services are found in the Benefit Summary. The summary explains Covered Services performed by a Medical Home. Details about Services	<u>Services received from Medical Homes or Specialists</u>~~with a Medical Home Referral~~: Some Services from a Medical Home or Specialist need Prior Authorization. The Provider must obtain this. This is true for Services completed from an In-Network Provider ~~through a medical Home Referral as well~~. <u>Services received</u> ~~without Medical Home Referral or~~ <u>from Out-of-Network Providers:</u> ~~You must submit Prior Authorization if you do not have a referral.~~ To receive Prior Authorization contact Providence Health Plan. The Out-of-Network Provider may also contact Providence Health Plan. Further details can be found in section 3.3. ***** <u>Failure to Obtain Prior Authorization</u>: If you do not obtain Prior Authorization for Services received from an Out-of-Network Provider ~~or without a Medical Home Referral~~, as specified in section 3.3, claims for those services will be denied and you will be responsible to pay those claims. ************* 3.12.2 Qualified Out-of-Area Dependent Coverage To be eligible for Qualified Out-of-Area Dependent coverage, you must apply to enroll. You must request permission. This will be done through Providence Health Plan. Eligibility is based on your home address. Students living Out-of-Area will use your school address to determine eligibility. A Dependent approved for Qualified Out-of-Area benefits may receive services In-Network. Only from Signature Network providers. Services can also be received Out-of-Network from Qualified Practitioners. ~~Referrals are not required.~~ Please refer to your Out-of-Area Dependent Benefit Summary. Details on Coinsurance or Copayment and annual Out-of-Pocket Maximum are found in this summary. ************* 4.2 WOMEN'S PREVENTIVE HEALTH CARE SERVICES ~~Women may choose to receive Women's Preventive Health Care Services from a Primary Care Provider or a Women's Health Care Provider without a referral.~~				

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			received through a Medical Home Referral to an In-Network Provider are also explained. ***** Medical Home Referral All services received outside of your Medical Home will require a referral from your Medical Home Provider, with the exception of emergency and urgent care. Referrals are requested through your Medical Home provider. These Services must be medically necessary. Services must be for an In-Network Provider outside of your medical home. Some services may require Prior Authorization in addition to a referral.	Women may choose to receive Women's Preventive Health Care Services from a Primary Care Provider or an In-Network Women's Health Care Provider. Women's Health Care Providers include physicians specializing in obstetrics, some Primary Care Providers and naturopaths (if they are licensed to provide the Services), physician assistants and nurse practitioners specializing in women's health care, certified nurse midwives and licensed direct entry midwives. ************* 4.6.1 Inpatient Hospital Services Benefits are provided, as shown in your Benefit Summary. **In-Network Benefit:** When your In-Network Provider and Providence Health Plan determine you need hospitalization, arrangements will be made for you to be admitted to an In-Network Hospital. **Out-of-Network Benefit:** It is your responsibility to make sure that inpatient hospitalization services are Prior Authorized. Prior Authorization must come from Providence Health Plan. Once approved, care can be received from an Out-of-Network Hospital. ~~A Medical Home Referral will not be needed for those Services.~~ ************* 14. DEFINITIONS ***** In-Network In-Network covered services are found in the Benefit Summary. The summary explains Covered Services performed by a Medical Home and other In-Network Providers. ~~Details about Services received through a Medical Home Referral to an In-Network Provider are also explained.~~ ***** ~~Medical Home Referral~~ ~~All services received outside of your Medical Home will require a referral from your Medical Home Provider, with the exception of emergency and urgent care. Referrals are requested through your Medical Home~~				

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				~~provider. These Services must be medically necessary. Services must be for an In-Network Provider outside of your medical home. Some services may require Prior Authorization in addition to a referral.~~				
Section 4.9.1 Medical Supplies (including Diabetes Supplies)	All Handbooks	Pharmacy product proposal approved to move select diabetic supplies to fall under prescription benefit (as opposed to medical benefit). Improves member experience and access to diabetic supplies by simplifying internal process.	4.9.1 Medical Supplies (including Diabetes Supplies) ***** 2. Diabetes supplies, such as needles, syringes, continuous glucose monitors and blood glucose monitors, lancets and test strips, may be purchased through Providence Health Plan participating medical supply providers or under this benefit at Participating Pharmacies. Formulary, Prior Authorization, and quantity limits may apply – please see your Formulary for details. See section 4.9.4 for coverage of diabetic equipment such as insulin pump devices. ************* 13.1.1 Using Your Prescription Drug Benefit ***** • Diabetes supplies and inhalation extender devices may be obtained at your Participating Pharmacy. However, these items are considered medical supplies and devices and are subject to your Medical Supplies benefits, limitations and Copayments and/or Coinsurances. See section 4.9.1 and your Benefit Summary. Diabetes supplies do not include insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.9.4.	4.9.1 Medical Supplies (including Diabetes Supplies) ***** 2. Diabetes supplies, such as needles, syringes, continuous glucose monitors and blood glucose monitors, lancets and test strips, may be purchased through Providence Health Plan participating medical supply providers <u>under your DME benefit. See section 4.14.1 for coverage of select diabetes supplies and formulary insulin pumps under your prescription benefit.</u> ~~or under this benefit at Participating Pharmacies.~~ Formulary, Prior Authorization, and quantity limits may apply – please see your Formulary for details. See section 4.9.4 for coverage of diabetic equipment such as insulin pump devices. ****** 13.1.1 Using Your Prescription Drug Benefit ***** • Diabetes supplies and inhalation extender devices may be obtained at your Participating Pharmacy. <u>Refer to your formulary for a list of diabetes supplies that may be covered under your prescription benefit when obtained at a pharmacy. All other continuous glucose monitors, insulin pumps, and all diabetic supplies obtained at a DME provider are considered medical supplies and devices.</u> ~~However, these items are considered medical supplies and devices and are subject to your Medical Supplies benefits, limitations and Copayments and/or Coinsurances.~~ See section 4.9.1 and your Benefit Summary. • ~~Diabetes supplies do not include i~~Insulin pump devices, <u>except those listed in your formulary,</u>~~which~~ are covered under your Durable Medical Equipment benefit~~,~~ <u>(</u>section 4.9.4<u>)</u>.	Yes	No		

0123 to 0124 ASO Contract Comparison – ACA non-grandfathered plans (non-GR)

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

DRAFT – 8/30/2023

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Section 4.14.8 Prescription Drug Exclusions	All Handbooks	Removing exclusion to cover all prenatal vitamins regardless of formulation.	4.14.8 Prescription Drug Exclusions In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 17. Prenatal vitamins that contain docosahexaenoic acid (DHA);	4.14.8 Prescription Drug Exclusions In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** ~~17. Prenatal vitamins that contain docosahexaenoic acid (DHA);~~	Yes	No	**Moved from Benefit Changes to Benefit Admin Changes, exclusion is mandatory per Pharmacy.**	
Category C: Language Changes Only – For all plan types, except as otherwise denoted								
Section 1, Introduction Section 3.11.1	Health Savings Account Handbooks only	Clarified deductible benefit in HSA plans, including more information about the Deductible and how Safe Harbor drugs are handled.	1. INTRODUCTION ***** ➢ Some Services are covered only under your In-Network benefits: • Tobacco Use Cessation Services, as specified in section 4.1.8; • Telehealth Services, as specified in section 4.3.2; • E-mail Visit Services, as specified in section 4.3.3; • Temporomandibular Joint (TMJ) Services, as specified in section 4.12.7; • Human Organ/Tissue Transplant Services, as specified in section 4.13; • Prescription Drug Services, as specified in section 4.11; • Any Supplemental Benefit included with your Plan that is designated as In-Network only, as specified in section 13; and • Any item listed in your Benefit Summary as "Not Covered" under Out-of-Network. ➢ Coverage is provided in full for most preventive Services when those Services are received from In-Network Providers. See your Benefit Summary for additional information. ************* 3.11.1 Understanding Deductibles Your Deductible is the dollar amount shown in the Benefit Summary that you are responsible to pay every	2. INTRODUCTION ***** ➢ Some Services are covered only under your In-Network benefits: • Tobacco Use Cessation Services, as specified in section 4.1.8; • Telehealth Services, as specified in section 4.3.2; • E-mail Visit Services, as specified in section 4.3.3; • Temporomandibular Joint (TMJ) Services, as specified in section 4.12.7; • Human Organ/Tissue Transplant Services, as specified in section 4.13; • Prescription Drug Services, as specified in section 4.11; • Any Supplemental Benefit included with your Plan that is designated as In-Network only, as specified in section 13; and • Any item listed in your Benefit Summary as "Not Covered" under Out-of-Network. ➢ Your Deductible is the dollar amount you must pay each Calendar Year before we provide benefits for Covered Services. Coverage is provided in full without meeting the Deductible for Safe Harbor drugs, subject to formulary tier, and most ~~most preventive Services when those Services are received from~~ In-Network preventive care~~Providers~~. See your Benefit Summary for Covered Services subject to the Deductible and additional information. *************	No	No		

0123 to 0124 ASO Contract Comparison – ACA non-grandfathered plans (non-GR)

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

DRAFT – 8/30/2023

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Understanding Deductibles			Calendar Year when receiving most Covered Services before benefits are provided by us. Deductible amounts are payable to your Qualified Practitioner after we have processed your claim. Certain Covered Services, such as most In-Network preventive care, are covered without a Deductible. Please see your Benefit Summary for information about these Services.	3.11.1 Understanding Deductibles Your Deductible is the dollar amount ~~shown in the Benefit Summary that~~ you must pay each ~~are responsible to pay every~~ Calendar Year before we provide benefits for Covered Services~~when receiving most Covered Services before benefits are provided by us~~. Deductible amounts are payable to your Qualified Practitioner after we have processed your claim. Certain Covered Services are covered without meeting the Deductible, including Safe Harbor drugs, subject to formulary tier,~~such as~~ and most In-Network preventive care~~, are covered without a Deductible~~. Please see your Benefit Summary for more information ~~about these Services~~.				
Section 2.2 Member Handbook Section 2.4 Registering for a myProvidence Account	All Handbooks	Removing web address from section 2.2 as benefit summaries are no longer available at ProvidenceHealthPlan.com, and also adding myProvidence.com web address to section 2.4 to better serve members in describing the process of registering for a myProvidence account.	2.2 MEMBER HANDBOOK ***** This Member Handbook is not complete without your: • Option Advantage Benefit Summary and any other Supplemental Benefit Summary documents. These documents are available at ProvidenceHealthPlan.com when you register for a myProvidence account as explained in section 2.4. Benefit Summaries detail your Copayments and Coinsurance for Covered Services and also provide important information for any Supplemental Benefits you may have, like Prescription Drug, Massage Therapy, Vision and Bariatric Surgery. ************* 2.4 REGISTERING FOR A MYPROVIDENCE ACCOUNT Members can create a myProvidence account online. A myProvidence account enables you to view your personal health plan information (including your Member Handbook and Benefit Summary), view claims history and benefit payment information, order a replacement Member ID Card, and access other health and wellness tools and services.	2.2 MEMBER HANDBOOK ***** This Member Handbook is not complete without your: • Option Advantage Benefit Summary and any other Supplemental Benefit Summary documents. These documents are available ~~at ProvidenceHealthPlan.com~~ when you register for a myProvidence account as explained in section 2.4. Benefit Summaries detail your Copayments and Coinsurance for Covered Services and also provide important information for any Supplemental Benefits you may have, like Prescription Drug, Massage Therapy, Vision and Bariatric Surgery. ************* 2.4 REGISTERING FOR A MYPROVIDENCE ACCOUNT Members can create a myProvidence account online at myProvidence.com. A myProvidence account enables you to view your personal health plan information (including your Member Handbook and Benefit Summary), view claims history and benefit payment information, order a replacement Member ID Card, and access other health and wellness tools and services.	No	No		

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Section 2.6 Providence Nurse Advice Line	All Handbooks	Updating language describing member experience for the nurse advice line due to a change in vendors.	2.6 PROVIDENCE NURSE ADVICE LINE 503-574-6520; toll-free 800-700-0481; TTY 711 The Providence nurse advice line is a free medical advice line for Providence Health Plan Members. Available 24 hours a day, seven days a week, a registered nurse can answer your health-related questions. Members often call the Providence nurse advice line when they have sick children, or when they have questions about how to treat flus, colds or backaches. After a brief recorded message, a registered nurse will come on line to assist you. Please have your Member ID Card available when you call.	2.6 PROVIDENCE NURSE ADVICE LINE 503-574-6520; toll-free 800-700-0481; TTY 711 The Providence nurse advice line is a free medical advice line for Providence Health Plan Members. Available 24 hours a day, seven days a week, a registered nurse can answer your health-related questions. Members often call the Providence nurse advice line when they have sick children, or when they have questions about how to treat flus, colds or backaches. After a brief message, a caregiver will ask you a few questions about why you're calling. A registered nurse will call you back to assist after reviewing your answers.~~After a brief recorded message, a registered nurse will come on line to assist you.~~ Please have your Member ID Card available when you call.	No	No		
Section 2.8 Privacy of Member Information	All Handbooks	Updated internal redirect links to external links.	2.8 PRIVACY OF MEMBER INFORMATION **** For more information about uses and disclosures of Member information, including uses and disclosures required by law, please refer to our Notice of Privacy Practices. A copy is available at [https://healthplans.providence.org/members/rights-notices] or by calling Customer Service. Appointment of Authorized Representative You are entitled to appoint an individual to act as your Authorized Representative to pursue any claim you have for benefits. To ensure privacy and to address other issues, Providence's policy on Appointment of Authorized Member Representatives, and the form for doing so, may be accessed through our website at [https://healthplans.providence.org/members/understanding-plans-benefits/benefit-basics/forms]. The policy does not apply to an attorney at law retained by you directly to represent your interests with respect to your	2.8 PRIVACY OF MEMBER INFORMATION **** For more information about uses and disclosures of Member information, including uses and disclosures required by law, please refer to our Notice of Privacy Practices. A copy is available at ProvidenceHealthPlan.com/nopp~~https://healthplans.providence.org/members/rights-notices~~ or by calling Customer Service. Appointment of Authorized Representative You are entitled to appoint an individual to act as your Authorized Representative to pursue any claim you have for benefits. To ensure privacy and to address other issues, Providence's policy on Appointment of Authorized Member Representatives, and the form for doing so, may be accessed through our website at ProvidenceHealthPlan.com/forms~~https://healthplans.providence.org/members/understanding-plans-benefits/benefit-basics/forms~~. The policy does not	No	No		

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

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			benefits, but does apply to attorneys who represent a medical service provider whose services are a part of the claim in issue. **** 3. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer. The details of this required certification can be reviewed at [https://healthplans.providence.org/about-us/privacy-notices-policies/protected-health-information-and-your-employer/]. ****	apply to an attorney at law retained by you directly to represent your interests with respect to your benefits, but does apply to attorneys who represent a medical service provider whose services are a part of the claim in issue. **** 3. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer. The details of this required certification can be reviewed at ProvidenceHealthPlan.com/nopp~~https://healthplans.providence.org/about-us/privacy-notices-policies/protected-health-information-and-your-employer/~~. ****				
Section 3.3.1 Understanding Protections Against Surprise Medical Bills	All Handbooks	Fixed capitalization for Glossary terms.	3.3.1 Understanding Protections Against Surprise Medical Bills **** 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.	3.3.1 Understanding Protections Against Surprise Medical Bills **** When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a ~~c~~Copayment, ~~c~~Coinsurance, and/or a ~~d~~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.	No	No		
Multiple Sections Section 4.3.5 Allergy Shots, Allergy Serums, Injectable and Infused Medications Section 13.1.1 Using Your	All Handbooks	Updating pharmacy URL	4.3.5 Allergy Shots, Allergy Serums, Injectable and Infused Medications Allergy shots, allergy serum, injectable medications, and total parenteral nutrition (TPN) received in your Provider's office are covered, as shown in your Benefit Summary. Therapy and testing for treatment of allergies including, but not limited to, Services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment are covered only when such therapy or testing is approved by the American Academy of Allergy and Immunology, or the Department of Health and Human Services or any of its offices or agencies. Some injectable medications may require Prior Authorization, as listed in the Medical benefit drug prior authorization list available on our	4.3.5 Allergy Shots, Allergy Serums, Injectable and Infused Medications Allergy shots, allergy serum, injectable medications, and total parenteral nutrition (TPN) received in your Provider's office are covered, as shown in your Benefit Summary. Therapy and testing for treatment of allergies including, but not limited to, Services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment are covered only when such therapy or testing is approved by the American Academy of Allergy and Immunology, or the Department of Health and Human Services or any of its offices or agencies. Some injectable medications may require Prior Authorization, as listed in the Medical benefit drug prior authorization list available on our	No	No		

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Prescription Drug Benefit			website at [https://healthplans.providence.org/members/pharmacy-resources/Pages/default.aspx] or by calling Customer Service. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. See section 4.7.1 for coverage of infusion at Outpatient Facilities. **** 4.14.1 Using Your Prescription Drug Benefit **** Participating Pharmacies are designated as retail, preferred retail, specialty and mail-order Pharmacies. To view a list of Participating Pharmacies, visit our website at [ProvidenceHealthPlan.com]. You also may contact Customer Service at the telephone number listed on your Member ID card. **** • You may purchase up to a 90-day supply of each maintenance drug at one time using a Participating mail service or preferred retail Pharmacy. Not all drugs are covered for more than a 30-day supply, including compounded medications, drugs obtained from specialty pharmacies, and limited distribution pharmaceuticals. To obtain prescriptions by mail, your physician or provider can call in or electronically send the prescription, or you can mail your prescription along with your Providence Health Plan Member ID number to one of our Participating mail-order Pharmacies. To find our Participating mail-order Pharmacies, please visit our website at [ProvidenceHealthPlan.com]. (Not all prescription drugs are available through our mail-order pharmacies). **** • Some prescription drugs require Prior Authorization or an exception to the formulary in order to be covered; these may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in	website at ProvidenceHealthPlan.com/pharmacy~~https://healthplans.providence.org/members/pharmacy-resources/Pages/default.aspx~~ or by calling Customer Service. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. See section 4.7.1 for coverage of infusion at Outpatient Facilities. **** 4.14.1 Using Your Prescription Drug Benefit **** Participating Pharmacies are designated as retail, preferred retail, specialty and mail-order Pharmacies. To view a list of Participating Pharmacies, visit our website at ProvidenceHealthPlan.com/pharmacy~~ProvidenceHealthPlan.com~~. You also may contact Customer Service at the telephone number listed on your Member ID card. **** • You may purchase up to a 90-day supply of each maintenance drug at one time using a Participating mail service or preferred retail Pharmacy. Not all drugs are covered for more than a 30-day supply, including compounded medications, drugs obtained from specialty pharmacies, and limited distribution pharmaceuticals. To obtain prescriptions by mail, your physician or provider can call in or electronically send the prescription, or you can mail your prescription along with your Providence Health Plan Member ID number to one of our Participating mail-order Pharmacies. To find our Participating mail-order Pharmacies, please visit our website at ProvidenceHealthPlan.com/pharmacy~~ProvidenceHealthPlan.com~~. (Not all prescription drugs are available through our mail-order pharmacies). **** • Some prescription drugs require Prior Authorization or an exception to the formulary				

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			our Prescription Drug Formulary available on our website at [ProvidenceHealthPlan.com] or by contacting Customer Service. **** 4.14.3 Prescription Drug Formulary **** To access the formulary for your plan, visit [https://healthplans.providence.org/members/pharmacy-resources/].	in order to be covered; these may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in our Prescription Drug Formulary available on our website at ProvidenceHealthPlan.com/pharmacy~~ProvidenceHealthPlan.com~~ or by contacting Customer Service. **** 4.14.3 Prescription Drug Formulary **** To access the formulary for your plan, visit ProvidenceHealthPlan.com/pharmacy][~~https://healthplans.providence.org/members/pharmacy-resources/~~				
Section 4.3.5 Allergy Shots, Allergy Serums, Injectable and Infused Medications	All Handbooks	Separating Allergy Shots and Allergy Serums from Injectable and Infused Medications into two subsections for clarification.	4.3.5 Allergy Shots, Allergy Serums, Injectable and Infused Medications Allergy shots, allergy serum, injectable medications, and total parenteral nutrition (TPN) received in your Provider's office are covered, as shown in your Benefit Summary. Therapy and testing for treatment of allergies including, but not limited to, Services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment are covered only when such therapy or testing is approved by the American Academy of Allergy and Immunology, or the Department of Health and Human Services or any of its offices or agencies. Some injectable medications may require Prior Authorization, as listed in the Medical benefit drug prior authorization list available on our website at [https://healthplans.providence.org/members/pharmacy-resources/Pages/default.aspx] or by calling Customer Service. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. See section 4.7.1 for coverage of infusion at Outpatient Facilities.	4.3.5 Allergy Shots~~,~~ and Allergy Serums~~, Injectable and Infused Medications~~ Allergy shots~~,~~ and allergy serums ~~, injectable medications, and total parenteral nutrition (TPN)~~ received in your Provider's office are covered, as shown in your Benefit Summary. Therapy and testing for treatment of allergies including, but not limited to, Services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment are covered only when such therapy or testing is approved by the American Academy of Allergy and Immunology, or the Department of Health and Human Services or any of its offices or agencies. ~~Some injectable medications may require Prior Authorization, as listed in the Medical benefit drug prior authorization list available on our website at [https://healthplans.providence.org/members/pharmacy-resources/Pages/default.aspx] or by calling Customer Service. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. See section 4.7.1 for coverage of infusion at Outpatient Facilities.~~ 4.3.6 Injectable and Infused Medications Injectable and infused medications received in your Provider's office are covered, as shown in your Benefit Summary. Some injectable medications may require	No	No		

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				Prior Authorization, as listed in the Medical benefit drug Prior Authorization list available at [ProvidenceHealthPlan.com/pharmacy] or by calling Customer Service. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. See section 4.7.1 for coverage of infusion at Outpatient Facilities.				
Section 4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Osteopathic Manipulation, Dialysis, Infusion, Chemotherapy, Radiation Therapy, and Multidisciplinary Pain Management Programs	All Handbooks	Adding clarifying language on possible requirements for self-administered drug benefit, and also updating subsection references for Injectable and Infused Medications.	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 designated location only if preferred location is less than 15 miles from a member's home. Member may utilize home infusion or their local site of care if no preferred site of care is located within 15 miles from a member's home. 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 4.3.6~~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 designated location only if preferred location is less than 15 miles from a member's home. Member may utilize home infusion or their local site of care if no preferred site of care is located within 15 miles from a member's home.~~ 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. Injectable or infused medications may require a Prior Authorization. For additional information about Prior	No	No		

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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.	Authorization, see section 3.5. Some injectable medication may be required to be supplied by a contracted Specialty Pharmacy. Infused medications may need to be administered at a designated location or a preferred site of care (refer to Infusion Therapy Site of Care Policy and Drug List, which can be found at [ProvidenceHealthPlan.com/pharmacy]) or may need to be self-administered. A list of drugs, the Self-Administered Drug List, is available at [ProvidenceHealthPlan.com/pharmacy]. After a transition period, the member will need to self-administer at home and the prescription drug benefit applies. For more information, see section 13.1. Member may use home infusion for most therapies. Home Infusion services are available and are usually necessary for total parenteral nutrition (TPN). Covered Services under these benefits do not include Services for Outpatient Rehabilitative Services. See section 4.7.2 for those Services.				
Section 4.9.1 Medical Supplies (including Diabetes Supplies)	All Handbooks	Moving the reference to TPN in the handbook; correcting TPN subsection reference.	4.9.1 Medical Supplies (including Diabetes Supplies) ***** 3. Medically Necessary medical foods for supplementation or dietary replacement including non-prescription elemental enteral formula for home use, when determined to be Medically Necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition. Medical foods are also covered for the treatment of Inborn Errors of Metabolism, as described in section 4.12.2. Medical foods do not include total parenteral nutrition (TPN), which is covered under section 4.3.5.	4.9.1 Medical Supplies (including Diabetes Supplies) ***** 3. Medically Necessary medical foods for supplementation or dietary replacement including non-prescription elemental enteral formula for home use, when determined to be Medically Necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition. Medical foods are also covered for the treatment of Inborn Errors of Metabolism, as described in section 4.12.2. Medical foods do not include total parenteral nutrition (TPN), which is covered under section 4.7.1.~~3.5.~~	No	No		
Section 4.12.12 Wigs	All Handbooks	Adding language to clarify what	4.12.12 Wigs The Plan will provide coverage for one synthetic wig every Calendar Year for Members who have undergone	4.12.12 Wigs The Plan will provide coverage for one ~~synthetic~~ wig every Calendar Year for Members who have undergone	No	No	Removing "synthetic" qualifier.	

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		constitutes a wig, for benefit purposes.	chemotherapy or radiation therapy or are experiencing drug-induced Alopecia at the Medical Equipment, Supplies and Devices benefit level listed in your Benefit Summary. Wigs may be purchased from any wig supplier. Wig suppliers may require Members to pay for items and submit the paid receipt to Providence Health Plan for reimbursement. For information about submitting claims, see section 6.1.1.	chemotherapy or radiation therapy or are experiencing drug-induced Alopecia at the Medical Equipment, Supplies and Devices benefit level listed in your Benefit Summary. A wig is a full cranial hair prosthesis to use as a hair loss solution or hair replacement. Wigs may be purchased from any wig supplier. Wig suppliers may require Members to pay for items and submit the paid receipt to Providence Health Plan for reimbursement. For information about submitting claims, see section 6.1.1.				
Multiple Sections	All Handbooks	Removing "experimental" from Transplant Exclusions per medical policy	4.13.6 Transplant Exclusions In addition to the exclusions listed in section 5, the following exclusions apply to human organ/tissue transplants: • Any transplant procedure performed at a transplant facility that has not been approved by us; • Any transplant that is Experimental/Investigational, as determined by us; • Services or supplies for any transplant that are not specified as Covered Services in section 4.13, such as transplantation of animal organs or artificial organs; • Services related to organ/tissue donation by a Member if the recipient is not a Member or the Member/recipient is not eligible for transplant benefits under this Plan; and • Transplant-related travel expenses for the donor and the donor's and recipient's Family Members. ************* 5. EXCLUSIONS ***** General Exclusions: We do not cover Services and supplies which: ***** • Are provided for treatment or testing required by a third party or court of law which is not Medically Necessary; • Are Experimental/Investigational;	4.13.6 Transplant Exclusions In addition to the exclusions listed in section 5, the following exclusions apply to human organ/tissue transplants: • Any transplant procedure performed at a transplant facility that has not been approved by us; • Any transplant that is ~~Experimental/~~Investigational, as determined by us; • Services or supplies for any transplant that are not specified as Covered Services in section 4.13, such as transplantation of animal organs or artificial organs; • Services related to organ/tissue donation by a Member if the recipient is not a Member or the Member/recipient is not eligible for transplant benefits under this Plan; and • Transplant-related travel expenses for the donor and the donor's and recipient's Family Members. ************* 5. EXCLUSIONS ***** General Exclusions: We do not cover Services and supplies which: ***** • Are provided for treatment or testing required by a third party or court of law which is not Medically Necessary; • Are ~~Experimental/~~Investigational;	No	No		

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			• Are determined by us not to be Medically Necessary for diagnosis and treatment of an injury or illness; • Are received by a Member under the Oregon Death with Dignity Act; • Have not been Prior Authorized as required by this Plan; and ************* 7.2 MEMBER GRIEVANCE AND APPEAL Definitions: Adverse Benefit Determination An Adverse Benefit Determination means a: • Denial of eligibility for or termination of enrollment in this Plan; • Rescission or cancellation of coverage under this Plan; • Source-of injury exclusion, network exclusion, Annual benefit limit or other limitation on otherwise Covered Services; • Determination that a health care item or service is Experimental/Investigational or not Medically Necessary; or • Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care. ************* 7.2.3 External Review If you are not satisfied with your internal Grievance or Appeal decision, you have the right to an external review by an Independent Review Organization (IRO). The IRO will determine if your case qualifies for external review. To qualify for external review, the case must involve (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care or (e) an exception to a prescription drug formulary. Your request must be made in writing within 180 days of receipt of the internal Grievance or Appeal decision, or that internal decision will become final. If you agree, we may waive the requirement that you exhaust the internal review process before beginning the External	• Are determined by us not to be Medically Necessary for diagnosis and treatment of an injury or illness; • Are received by a Member under the Oregon Death with Dignity Act; • Have not been Prior Authorized as required by this Plan; and ************* 7.2 MEMBER GRIEVANCE AND APPEAL Definitions: Adverse Benefit Determination An Adverse Benefit Determination means a: • Denial of eligibility for or termination of enrollment in this Plan; • Rescission or cancellation of coverage under this Plan; • Source-of injury exclusion, network exclusion, Annual benefit limit or other limitation on otherwise Covered Services; • Determination that a health care item or service is ~~Experimental/~~Investigational or not Medically Necessary; or • Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care. ************* 7.2.3 External Review If you are not satisfied with your internal Grievance or Appeal decision, you have the right to an external review by an Independent Review Organization (IRO). The IRO will determine if your case qualifies for external review. To qualify for external review, the case must involve (a) Medically Necessary treatment, (b) ~~Experimental/~~Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care or (e) an exception to a prescription drug formulary. Your request must be made in writing within 180 days of receipt of the internal Grievance or Appeal decision, or that internal decision will become final. If you agree, we may waive the requirement that you exhaust the internal review process before beginning the External				

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			Review process. We will notify the Oregon Division of Financial Regulation within two business days of receiving your request for external review, at which point an IRO will be assigned to the case by the Oregon Division of Financial Regulation and we will forward complete documentation regarding the case to the IRO. ************* 14. DEFINITIONS ***** <u>Essential Health Benefits</u> Essential Health Benefits means the general categories of Services established under section 1302(b) of the Patient Protection and Affordable Care Act (PPACA) and applicable regulations: • Ambulatory patient Services; • Emergency Services; • Hospitalization; • Maternity and newborn care; • Mental Health and Substance Use Disorder Services; • Prescription drugs; • Rehabilitative and habilitative Services and devices; • Laboratory Services; • Preventive and wellness Services and chronic disease management; and • Pediatric Services, including dental and vision care. <u>Experimental/Investigational</u> Experimental/Investigational means Services for which current, prevailing, evidence-based, peer-reviewed medical literature does not demonstrate the safety and effectiveness of the Service for treating or diagnosing the condition or illness for which its use is proposed. In determining whether Services are Experimental/Investigational the Plan considers a variety of criteria, which include, but are not limited to, whether the Services are: • Approved by the appropriate governmental regulatory body;	Review process. We will notify the Oregon Division of Financial Regulation within two business days of receiving your request for external review, at which point an IRO will be assigned to the case by the Oregon Division of Financial Regulation and we will forward complete documentation regarding the case to the IRO. ************* 14. DEFINITIONS ***** <u>Essential Health Benefits</u> Essential Health Benefits means the general categories of Services established under section 1302(b) of the Patient Protection and Affordable Care Act (PPACA) and applicable regulations: • Ambulatory patient Services; • Emergency Services; • Hospitalization; • Maternity and newborn care; • Mental Health and Substance Use Disorder Services; • Prescription drugs; • Rehabilitative and habilitative Services and devices; • Laboratory Services; • Preventive and wellness Services and chronic disease management; and • Pediatric Services, including dental and vision care. ~~<u>Experimental/Investigational</u>~~ ~~Experimental/Investigational means Services for which current, prevailing, evidence-based, peer-reviewed medical literature does not demonstrate the safety and effectiveness of the Service for treating or diagnosing the condition or illness for which its use is proposed. In determining whether Services are Experimental/Investigational the Plan considers a variety of criteria, which include, but are not limited to, whether the Services are:~~ ~~• Approved by the appropriate governmental regulatory body;~~				

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			• Subject to review and approval of an institutional review board (IRB) or are currently offered through an approved clinical trial; • Offered through an accredited and proficient provider in the United States; • Reviewed and supported by national professional medical societies; • Address the condition, injury, or complaint of the Member and show a demonstrable benefit for a particular illness or disease; • Proven to be safe and efficacious; and • Pose a significant risk to the health and safety of the Member. The experimental/investigational status of a Service may be determined on a case-by-case basis. We will retain documentation of the criteria used to define a Service as Experimental/Investigational and will make this available for review upon request. Family Member Family Member means an Eligible Family Dependent who is properly enrolled in and entitled to Services under the Group Contract. For the purpose of ORS 743.730 the term "Member" satisfies the definition of "enrollee." **** Ineligible Person Ineligible Person means any person who does not qualify as a Member under the Group Contract. Medically Necessary Medically Necessary means Covered Services that are in the reasonable opinion of Providence Health Plan, consistent with the written criteria regarding medically indicated Covered Services that are maintained by us. *****	~~• Subject to review and approval of an institutional review board (IRB) or are currently offered through an approved clinical trial;~~ ~~• Offered through an accredited and proficient provider in the United States;~~ ~~• Reviewed and supported by national professional medical societies;~~ ~~• Address the condition, injury, or complaint of the Member and show a demonstrable benefit for a particular illness or disease;~~ ~~• Proven to be safe and efficacious; and~~ ~~• Pose a significant risk to the health and safety of the Member.~~ ~~The experimental/investigational status of a Service may be determined on a case-by-case basis. We will retain documentation of the criteria used to define a Service as Experimental/Investigational and will make this available for review upon request.~~ Family Member Family Member means an Eligible Family Dependent who is properly enrolled in and entitled to Services under the Group Contract. For the purpose of ORS 743.730 the term "Member" satisfies the definition of "enrollee." **** Ineligible Person Ineligible Person means any person who does not qualify as a Member under the Group Contract. Investigational Investigational means Services for which current, prevailing, evidence-based, peer-reviewed medical literature does not demonstrate the safety and effectiveness of the Service for treating or diagnosing the condition or illness for which its use is proposed. In determining whether Services are Investigational the Plan considers a variety of criteria, which include, but are not limited to, whether the Services are: • Approved by the appropriate governmental regulatory body;				

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				• Subject to review and approval of an institutional review board (IRB) or are currently offered through an approved clinical trial; • Offered through an accredited and proficient provider in the United States; • Reviewed and supported by national professional medical societies; • Address the condition, injury, or complaint of the Member and show a demonstrable benefit for a particular illness or disease; • Proven to be safe and efficacious; and • Pose a significant risk to the health and safety of the Member. The Investigational status of a Service may be determined on a case-by-case basis. We will retain documentation of the criteria used to define a Service as Investigational and will make this available for review upon request. Medically Necessary Medically Necessary means Covered Services that are in the reasonable opinion of Providence Health Plan, consistent with the written criteria regarding medically indicated Covered Services that are maintained by us. *****				
Section 4.14 Prescription Drug Supplemental Benefit	All Handbooks	Clarifies division between Allergy Shots/Serums and Injected/Infused medications into two subsections. Further clarifies self-administered medications.	4.14 PRESCRIPTION DRUG SUPPLEMENTAL BENEFIT ***** Prescription Drugs, including oral, topical and injectable medications delivered, injected or administered to you by a physician, other provider, or trained person in a Provider's office or other facility are not covered under your Prescription Drug Benefit. Prescription drugs administered in a Provider's office or other facility are subject to the applicable benefit. For example, Prescription Drugs delivered in a Provider's Office are subject to your Allergy Shots, Allergy Serums, Injectable and Infused Medications benefit. See section 4.3.5. Select self-administered injectable medications may allow for a 60-day transition period for a member to	4.14 PRESCRIPTION DRUG SUPPLEMENTAL BENEFIT ***** Prescription Drugs, including oral, topical and injectable medications delivered, injected or administered to you by a physician, other provider, or trained person in a Provider's office or other facility are not covered under your Prescription Drug Benefit. Prescription drugs administered in a Provider's office or other facility are subject to the applicable benefit. For example, Prescription Drugs delivered in a Provider's Office may beare subject to your Allergy Shots, and Allergy Serums, ~~Injectable and Infused Medications~~ benefit (see section 4.3.5). For details about Injectable and Infused	No	No		

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			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.	Medications, refer to sections 4.3.6, 4.7.1, and 4.14.1. ~~See section 4.3.5.~~ Select self-administered injectable medications are medications which have been identified as being medically appropriate for administration by a patient or their caregiver, safely and effectively, without medical supervision. Certain medications considered to be usually self-administered by the patient or their caregiver are excluded from coverage under the medical benefit without Prior Authorization. A transition period may be allowed for a member to receive the drug at the Provider's office, clinic, or facility. ~~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 Resources website at [ProvidenceHealthPlan.com/pharmacy]. After this transition period, the member will need to self-administer at home and ~~Y~~your ~~p~~Prescription ~~d~~Drug ~~b~~Benefit applies.				
Section 4.14.1 Using Your Prescription Drug Benefit	All Handbooks	Actual system setup has Member Pay Difference applying if member OR provider chooses brand name drug when generic is available. This aligns language with administrative process.	4.14.1 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 choose a brand-name drug when a generic is available, you will be required to pay for the difference in cost between the 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.	4.14.1 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 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.	No	No		
Section 4.14.1 Using Your	All Handbooks except for Health	This language change ensures all dollar-applying	4.14.1 Using Your Prescription Drug Benefit *****	4.14.1 Using Your Prescription Drug Benefit *****	No	No		

0123 to 0124 ASO Contract Comparison – ACA non-grandfathered plans (non-GR)

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

DRAFT – 8/30/2023

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Prescription Drug Benefit	Savings Account plans	language is reconciled across the handbook for SmartRx Assist program.	• The amount paid by a manufacturer discount and/or copay assistance programs will apply towards your Calendar Year Deductibles and Out-of-Pocket Maximums.	• The amount paid by a manufacturer discount and/or copay assistance programs will apply towards your Calendar Year Deductibles and Out-of-Pocket Maximums, except for amounts paid under the Specialty Pharmacy Variable Copay Program.				
Section 4.14.1 Using Your Prescription Drug Benefit	All Handbooks	Updating subsection reference for Injectable and Infused Medications, as it has been given its own subsection. Additionally, removing specific number of days for transition period as the period is medication-specific.	4.14.1 Using Your Prescription Drug Benefit **** • Self-administered injectable medications are not covered when supplied in a provider's office, clinic, or facility. Injectable or infused medications received in your Provider's office are covered by your medical benefit found in 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. Please refer to the Providence Pharmacy Resource website at [ProvidenceHealthPlan.com/pharmacy] for the Self-Administered Drug list. After this transition period, you will need to self-administer at home and your prescription drug benefit applies.	4.14.1 Using Your Prescription Drug Benefit **** • Self-administered injectable medications are not covered when supplied in a provider's office, clinic, or facility. Injectable or infused medications received in your Provider's office are covered by your medical benefit found in section 4.3.~~6~~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. Please refer to the Providence Pharmacy Resource website at [ProvidenceHealthPlan.com/pharmacy] for the Self-Administered Drug list. After this transition period, you will need to self-administer at home and your prescription drug benefit applies.	No	No		
Section 4.14.7 Prescription Drug Limitations	All Handbooks	Bullet #7 Aligns language with administrative process. Bullet #8 updating to broader language to not convey a guarantee to members.	4.14.7 Prescription Drug Limitations Prescription drug limitations are as follows: ***** 7. Vacation supply overrides are limited to a 30-day supply once per Calendar Year. Additional exceptions may be granted on a case-by-case basis. 8. A 30-day supply override will be granted if you are out of medication and have not yet received your drugs from a Participating mail-order Pharmacy.	4.14.7 Prescription Drug Limitations Prescription drug limitations are as follows: ***** 7. Vacation supply overrides are limited to a 30-day supply ~~once per Calendar Year. Additional exceptions may be granted on a case-by-case basis~~. 8. A 30-day supply override may~~will~~ be granted if you are out of medication and have not yet received your drugs from a Participating mail-order Pharmacy.	No	No		

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Section 5 Exclusions	All Handbooks	Adding specifying language for Supplemental Benefits for Bariatric Surgery into the exclusion for weight loss services and supplies.	5. EXCLUSIONS ***** 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;	5. EXCLUSIONS ***** 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;	No	No		
Section 5 Exclusions Section 13 Definitions	All Handbooks	Updated language around the Diagnostic and Statistical Manual to avoid referencing specific editions for futureproofing.	5. EXCLUSIONS **** • 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 Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis; **** 13. DEFINITIONS **** Mental Health Mental Health means any mental disorder covered by diagnostic categories listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), such as, but not limited to, major depressive disorder, autism spectrum disorder, dissociative identity disorder, gender dysphoria, and Substance Use Disorder. ****	5. EXCLUSIONS **** • 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)~~Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis~~; **** 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), ~~Fourth Edition (DSM-IV) or the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5),~~ such as, but not limited to, major depressive disorder, autism spectrum disorder, dissociative identity disorder, gender dysphoria, and Substance Use Disorder. ****	No	No		

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Section 9.4 Notice of Creditable Coverage	All Handbooks	Removing references to creditable coverage	9.4 NOTICE OF CREDITABLE COVERAGE We will provide, upon request, written certification of the Member's period of Creditable Coverage when: • A Member ceases to be covered under this Plan; • A Member on COBRA coverage ceases that coverage; and • A Member requests a Notice of Creditable Coverage within 24 months of the termination of coverage.	9.4 PROOF OF PRIOR ~~NOTICE OF CREDITABLE~~ COVERAGE We will provide, upon request or as required by law, proof of prior coverage. ~~, written certification of the Member's period of Creditable Coverage when:~~ • ~~A Member ceases to be covered under this Plan;~~ • ~~A Member on COBRA coverage ceases that coverage; and~~ • ~~A Member requests a Notice of Creditable Coverage within 24 months of the termination of coverage.~~	No	No		
Section 14 Definitions	All Handbooks	Removing reference to "behavioral health treatment" to better align with standard language regarding mental health and substance use disorder services.	14. DEFINITONS ***** Essential Health Benefits Essential Health Benefits means the general categories of Services established under section 1302(b) of the Patient Protection and Affordable Care Act (PPACA) and applicable regulations: • Ambulatory patient Services; • Emergency Services; • Hospitalization; • Maternity and newborn care; • Mental Health and Substance Use Disorder Services, including behavioral health treatment; • Prescription drugs; • Rehabilitative and habilitative Services and devices; • Laboratory Services; • Preventive and wellness Services and chronic disease management; and • Pediatric Services, including dental and vision care.	14. DEFINITONS ***** Essential Health Benefits Essential Health Benefits means the general categories of Services established under section 1302(b) of the Patient Protection and Affordable Care Act (PPACA) and applicable regulations: • Ambulatory patient Services; • Emergency Services; • Hospitalization; • Maternity and newborn care; • Mental Health and Substance Use Disorder Services~~, including behavioral health treatment~~; • Prescription drugs; • Rehabilitative and habilitative Services and devices; • Laboratory Services; • Preventive and wellness Services and chronic disease management; and • Pediatric Services, including dental and vision care.	No	No		
Diagnostic and	All Handbooks	Adding Diagnostic and Supplemental	N/A	"Diagnostic Breast Examination" is defined as a medically necessary and appropriate examination of the breast, including examinations using diagnostic	Yes	Yes, WA SSB 5396 and OR SB 1041	**Moved to Language Changes from Benefit Changes:** Plans already administered in compliance with new senate bills.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group non-grandfathered plans, as filed with the State of Oregon DFR for plan year 2024. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0123 documents)	New Language & Provisions (in new 0124 documents)	Benefit or Benefit Administration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
Supplemental Breast Exams		Breast Exams definitions		mammography, digital breast tomosynthesis, breast magnetic resonance imaging, or breast ultrasound, used to evaluate an abnormality. **"Supplemental breast examination"** means a medically necessary and appropriate examination of the breast, including an examination using breast magnetic resonance imaging or breast ultrasound, that is: (i) Used to screen for breast cancer when there is no abnormality seen or suspected; and (ii) Based on personal or family medical history, or additional factors that may increase the individual's risk of breast cancer.			SSB 5396 and OR SB 1041 prohibits non-grandfathered plans from imposing any form of cost-sharing to its members for diagnostic and supplemental breast examinations.	
Diagnostic and Supplemental Breast Exams	All Benefit Summaries	Adding Diagnostic and Supplemental Breast Exams under diagnostic services	N/A	Diagnostic Services Diagnostic and supplemental breast exams [Covered in full][✓]	Yes	Yes, WA SSB 5396 and OR SB 1041	Plans already administered in compliance with new senate bills. SSB 5396 and OR SB 1041 prohibits non-grandfathered plans from imposing any form of cost-sharing to its members for diagnostic and supplemental breast examinations.	
Back Cover Page, TTY Phone Number Correction	All Handbooks	Final page of handbook incorrectly lists TTY access number as 771, needs correction to 711.	**Questions? We're here to help.** Speak to one of our Customer Service representatives at 503-574-7500 or 800-878-4445 (TTY: 771), 8 a.m. to 5 p.m. (Pacific Time) Monday through Friday. **ProvidenceHealthPlan.com**	**Questions? We're here to help.** Speak to one of our Customer Service representatives at 503-574-7500 or 800-878-4445 (TTY: 71~~7~~1), 8 a.m. to 5 p.m. (Pacific Time) Monday through Friday. **ProvidenceHealthPlan.com**	No	No		