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

Open Option, Personal Option

FINAL – 11/09/2023

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Category A: Optional Benefit Changes – For all plan types, except as otherwise denoted								
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).	**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 under your DME benefit. See section 4.14.1 for coverage of select diabetes supplies and formulary insulin pumps under your prescription benefit. ~~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. 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. ~~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, except those listed in your formulary,~~which~~ are covered under your Durable Medical Equipment benefit~~,~~ (section 4.9.4).	Yes	No	**Note:** Acceptance is *optional.*	☐ Yes ☐ No

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4.12.11 Hearing Loss Services	All Handbooks	Updates to hearing loss coverage to include components and maintenance services for certain hearing assistance devices.	**4.12.15 Hearing Loss Services** ********** **Cochlear implants:** Cochlear implants for one or both ears, including programming, reprogramming, replacement and repair expenses. Cochlear Implants require Prior Authorization. The devices are covered under the Medical Appliances benefit. The implantation services are covered under the Surgery and applicable Facility benefit. **Hearing aids & related accessories:** Medically Necessary external hearing aids and devices, as prescribed, fitted, and dispensed by a licensed audiologist or a hearing aid/instrument specialist. Hearing aids and devices are covered under the Medical Appliances benefit. This benefit is available for one hearing aid per ear every three Calendar Years for all Members. Hearing aid batteries are covered for one box per hearing aid per Calendar Year. **Diagnostic & Treatment Services:** Medically Necessary diagnostic and treatment services, including office visits for hearing tests appropriate for member's age or development need, hearing aid checks, and aided testing. Services are covered under the applicable benefit level for the service received. For example, office visits with an audiologist are covered under the Specialist office visit benefit. **Hearing Assistance Technology:** • Bone conduction sound processors, if necessary for appropriate amplification of hearing loss. This benefit is available once every three Calendar Years for all Members. • Hearing assistive technology systems, if necessary, for appropriate amplification of hearing loss. This benefit is available once	**4.12.15 Hearing Loss Services** ********** **Cochlear implants:** • Cochlear implants for one or both ears, including fitting, programming, reprogramming, replacement and repair ~~expenses~~. Cochlear Implants require Prior Authorization. The devices are covered under the Durable Medical Equipment~~Medical Appliances~~ benefit. The implantation services are covered under the Surgery and applicable Facility benefit. These services and devices are not subject to your Deductible in-network. **Hearing aids & related accessories:** • Medically Necessary external hearing aids and devices, as prescribed, fitted, and dispensed by a licensed audiologist or a hearing aid/instrument specialist. Hearing aids and devices are covered under the Medical Appliances benefit. This benefit is available for one hearing aid per ear every three Calendar Years for all Members. Hearing aid batteries are covered for one box per hearing aid per Calendar Year. These services and devices are not subject to your Deductible in-network. **Diagnostic & Treatment Services:** • Medically Necessary diagnostic and treatment services, including office visits for hearing tests appropriate for member's age or development need, hearing aid checks, and aided testing. Services are covered under the applicable benefit level for the service received. For example, office visits with an audiologist are covered under the Specialist office visit benefit. These services and devices are not subject to your Deductible in-network.	Yes	Yes, OR HB 2994	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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			every three Calendar Years for all Members. **Limits to Hearing Loss Services** Coverage for hearing loss services are provided in accordance with state and federal law.	**Hearing Assistance Technology:** • Bone conduction sound processor~~s~~ headbands and prosthetic parts, if necessary for appropriate amplification of hearing loss. This benefit is available once every three Calendar Years for all Members. • Hearing assistive technology systems, if necessary, for appropriate amplification of hearing loss. This benefit is available once every three Calendar Years for all Members. • Necessary repair or replacement of such devices when the cost is not covered by a warranty. • These Services and devices are not subject to your Deductible in-network. **Limits to Hearing Loss Services** Coverage for hearing loss services are provided in accordance with state and federal law.				
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.	Yes	No	**Note:** Acceptance is *optional*, however, PHP recommends adoption to provide a better benefit for members.	☐ Yes ☐ No

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				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.				
First 3 PCP and MH/SUD visits coverage	All Benefit Summaries	First 3 PCP visits and first 3 Mental Health and Substance Use Disorder 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%][✓]** ********** **Mental Health and Substance Use Disorder** **[(Services, except outpatient provider office visits, may require prior authorization.)]** Outpatient provider visits [(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%][✓]** ********** **Mental Health and Substance Use Disorder** **[(Services, except outpatient provider office visits, may require prior authorization.)]** Outpatient provider visits [(in-person or virtually)] [In-person] ~~[Covered in full] [$5-$200] [5%-50%][✓]~~ [First (1-3) Visits] [$5] [✓] [Then] [$5-$200] [5%-50%][✓] [Virtually]	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

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				[Covered in full] [$5-$200] [5%-50%][✓]				
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
Category B: Benefit Administration Changes – For all plan types, except as otherwise denoted								
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		
Category C: Language Changes Only – For all plan types, except as otherwise denoted								
Section 2.2 Member Handbook	All Handbooks	Removing web address from section 2.2 as benefit summaries are no longer available at ProvidenceHealthPlan.com, and also adding	**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	**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	No	No		

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Section 2.4 Registering for a myProvidence Account		myProvidence.com web address to section 2.4 to better serve members in describing the process of registering for a myProvidence account.	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.	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.				
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	**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	No	No		

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

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Multiple Sections Diagnostic and Supplemental Breast Exams	All Handbooks	Adding section describing the differences between Diagnostic and Supplemental Breast Exams, as well as reference to new section under Mammograms.	**4.2.2 Mammograms** Mammograms are covered for women over 40 years of age once every Calendar Year. If the Member is designated high risk, mammograms are covered as recommended by the Qualified Practitioner or Women's Health Care Provider.	**4.2.2 Mammograms** Mammograms are covered for women over 40 years of age once every Calendar Year. If the Member is designated high risk, mammograms are covered as recommended by the Qualified Practitioner or Women's Health Care Provider. See section 4.4.3 for diagnostic and supplemental breast examinations. ********** **4.4.3 Diagnostic and Supplemental Breast Examinations** Coverage is provided for diagnostic and supplemental breast examinations. Diagnostic breast exams are used to evaluate an abnormality of the breast that is detected or suspected from a screening examination for breast cancer or by any other means of examination using diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound. Supplemental breast examinations include breast magnetic resonance imaging or a breast ultrasound. These exams are used to screen for breast cancer when there is no abnormality seen or suspected but there is an increased risk of breast cancer based on personal or family medical history or other factors. See section 4.2.2 for annual preventive mammograms.	No	No		
Multiple Sections Section 4.3.5 Allergy Shots, Allergy Serums, Injectable and Infused Medications	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	**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	No	No		

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Section 13.1.1 Using Your Prescription Drug Benefit			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. **** **4.14.1 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). ****	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 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				

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			• 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 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/].**	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 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.~~	No	No		

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

Open Option, Personal Option

FINAL – 11/09/2023

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				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 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	**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	No	No		

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			Prior Authorize the Services. For additional information about Prior Authorization, see section 3.5. Covered Services under these benefits do not include Services for Outpatient Rehabilitative Services. See section 4.7.2 for those Services.	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 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)** ***** 1. 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		

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Section 4.12.12 Wigs	All Handbooks	Adding language to clarify what constitutes a wig, for benefit purposes.	**4.12.12 Wigs** The Plan will provide coverage for one synthetic wig every Calendar Year for Members who have undergone 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.	**4.12.12 Wigs** The Plan will provide coverage for one ~~synthetic~~ wig every Calendar Year for Members who have undergone 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.	No	No		
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** *****	**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** *****	No	No		

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			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; • 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	**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; • 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** ***** **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; • 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. **Experimental/Investigational** 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** ***** **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; • 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. ~~**Experimental/Investigational**~~ ~~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 bear~~e~~ 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		

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Section 4.14.1 Using Your Prescription Drug Benefit	All Handbooks	This language change ensures all dollar-applying language is reconciled across the handbook for SmartRx Assist program.	**4.14.1 Using Your Prescription Drug Benefit** ***** • The amount paid by a manufacturer discount and/or copay assistance programs will apply towards your Calendar Year Deductibles and Out-of-Pocket Maximums.	**4.14.1 Using Your Prescription Drug Benefit** ***** • 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.	No	No		
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 4.3.65. 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		

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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		
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	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; ****	**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~~; ****	No	No		

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Section 13 Definitions			**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. ****	**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. ****				
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		

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Section 13.1.4 Prescription Drugs	All Handbooks	Adding language describing the formulary exception process.	**13.1.4 Prescription Drugs** • **Generic and Brand-Name Prescription Drugs** Both generic and brand-name drugs are covered benefits subject to the terms of your Benefit Summary. In general, generic drugs are subject to lower Copayments or Coinsurances than brand-name drugs. Please refer to your Benefit Summary for your Copayment or Coinsurance information. 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.	**13.1.4 Prescription Drugs** • **Generic and Brand-Name Prescription Drugs** Both generic and brand-name drugs are covered benefits subject to the terms of your Benefit Summary. In general, generic drugs are subject to lower Copayments or Coinsurances than brand-name drugs. Please refer to your Benefit Summary for your Copayment or Coinsurance information. 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.	No	Yes, 45 CFR 156.122(c)		

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Section 14 Definitions	All Handbooks	Removing same sex requirement from definition of Domestic Partner per Oregon law.	**14. DEFINITIONS** ********** **Domestic Partner** A Domestic Partner is: • At least 18 years of age; and • Has entered into a domestic partnership with a member of the same sex; and • Has legally registered a Declaration of Domestic Partnership and obtained a Certificate of Registered Domestic Partnership in accordance with Oregon state law. Note: All provisions of this Group Contract that apply to a Spouse shall apply to a Domestic Partner.	**14. DEFINITIONS** ********** **Domestic Partner** A Domestic Partner is: • At least 18 years of age; and • Has entered into a domestic partnership ~~with a member of the same sex~~; and • Has legally registered a Declaration of Domestic Partnership and obtained a Certificate of Registered Domestic Partnership in accordance with Oregon state law. Note: All provisions of this Group Contract that apply to a Spouse shall apply to a Domestic Partner.	No	Yes, OR HB 2032		

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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 Supplemental Breast Exams	All Handbooks	Adding Diagnostic and Supplemental Breast Exams definitions	**N/A**	**14. DEFINITIONS** ********** **Diagnostic Breast Examination** Diagnostic Breast Examination means a medically necessary and appropriate examination of the breast, including an examination using diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound, that is used to evaluate an abnormality: • Seen or suspected from a screening examination for breast cancer; • Or detected by another means of examination. ****	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.	

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				Supplemental Breast Examination 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: • Used to screen for breast cancer when there is no abnormality seen or suspected; and • Based on personal or family medical history, or additional factors that may increase the individual's risk of breast cancer.				
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: 7~~17~~1), 8 a.m. to 5 p.m. (Pacific Time) Monday through Friday. **ProvidenceHealthPlan.com**	No	No		