Memo

Date: July 26, 2022
To: Clackamas County Board of Commissioners
From: Human Resources – Kristi Durham, Benefits Manager

Subject: Approval of 2022 Agreements with Providence Health Plan for Administrative Services for Clackamas County's Self-Funded Medical Benefits. Total value is $26,981,400. Funding through contributions and fees paid by county departments, employees, retirees, COBRA beneficiaries, and other agencies contracting with Clackamas County for employee benefits administration. County general funds are not involved.

Human Resources is seeking formal approval of the Clackamas County Providence medical benefit plan Administrative Services Agreement (ASA) Amendment and the five Summary Plan Descriptions (SPDs) for the 2022 plan year. All six documents require Board signature at a future consent agenda.

The changes to the original 2015 ASA between Clackamas County and Providence Health Plan are described in the attached 2022 ASA Amendment (Exhibit A). These changes were reviewed and approved by County Counsel, Human Resources Benefits and Wellness Division, and Clackamas County's benefit advisors, Mercer.

The 2022 SPDs include language changes that are both legislatively required and optional. The optional changes were approved by the Benefits Review Committee (BRC) and Joint Peace Officers/County Benefits Committee (POA BRC) in November 2021 (Exhibits B and C).

The optional changes approved by the two benefit committee's include:

- General County Plans:
  - Fertility Preservation Services (Exhibit B, Pages 5-6)
  - Gender Dysphoria Benefit (Exhibit B, Pages 6-7)
  - Travel Transplant Services (Exhibit B, Page 7)
- Peace Officers Association Plans:
  - Fertility Preservation Services (Exhibit C, Pages 2-3)
  - Gender Dysphoria Benefit (Exhibit C, Pages 3-4)
  - Travel Transplant Services (Exhibit C, Page 7)

The final SPDs have been reviewed by County Counsel, Human Resources Benefits and Wellness Division, and Clackamas County's benefit advisors, Mercer.

FINANCIAL IMPLICATIONS

This item is in the current budget of the Self Insurance Fund. The General Fund does not pay the benefit premiums noted below. The funding is through contributions and fees paid by county departments, employees, retirees, COBRA beneficiaries, and other agencies contracting with Clackamas County for employee benefits administration.

The estimated fiscal impact for the 2022 Providence Medical/Vision plan year based on current enrollment is $26,981,400.

STRATEGIC PLAN ALIGNMENT

This project directly supports Human Resource's Strategic Result #5 to align wellness programs with workforce needs.

The purpose of the Benefits program is to provide cost-effective, responsive and comprehensive benefit services to County departments, current, retired employees and their family members so they can better serve the residents of Clackamas County.

OPTIONS

1. Approve Providence medical benefit plan Administrative Services Agreement (ASA) Amendment and the five Summary Plan Descriptions (SPDs) for the 2022 plan year, and direct staff to bring the items to a future consent agenda for consideration.

2. Direct staff to schedule a policy session to discuss the ASA amendment and SPD changes in further detail.

RECOMMENDATION

Staff recommends option 1: Approve Providence medical benefit plan Administrative Services Agreement (ASA) Amendment and the five Summary Plan Descriptions (SPDs) for the 2022 plan year, and direct staff to bring the items to a future consent agenda for consideration.

ATTACHMENTS

1. 2022 Administrative Services Agreement Amendment (Exhibit A)
2. 0121 to 0122 ASO Contract Comparison – ACA Non-Grandfathered Plans (Exhibit B)
3. 0121 to 0122 ASO Contract Comparison – ACA Grandfathered Plans (Exhibit C)

THIS AMENDMENT NO. 7 TO THE ADMINISTRATIVE SERVICES AGREEMENT (this "Amendment") is entered into as of January 1, 2022, by and between Clackamas County ("Plan Sponsor") and Providence Health Plan ("Providence"). Plan Sponsor and Providence are sometimes referred to in this Amendment as a "Party" or, collectively, as the "Parties."

RECITALS

A. Plan Sponsor and Providence entered into that certain Administrative Services Agreement dated on or around January 1, 2015 ("Services Agreement").

B. The Parties wish to amend the Services Agreement as set forth herein.

AMENDMENT

The Parties hereby agree as follows:

1. **Section 5.3.** The following provision in Section 5.3 (Claims Processing) is amended and restated in its entirety as follows:

   Conscience Clause. Providence Health Plan is a Catholic-sponsored organization and, as a matter of conscience, does not offer services for voluntary termination of pregnancy or certain infertility services involving the creation or destruction of human embryos. To the extent that such services are a covered benefit under the Plan, we will coordinate the administration of related claims through a third-party administrator. That administrator, however, will be solely responsible for their performance of administrative duties, under a separate agreement that you execute with them.

2. **Section 6.3.** The following provision in Section 6.3 (Pharmacy Rebate Program) is amended and restated in its entirety as follows:

   During the period the Agreement is in effect, and for a period of 12 months following the termination of this agreement, PHP will pass through to Clackamas County 100% of all rebate revenue attributable to Clackamas County's prescription drug claims, minus applicable administration fees not to exceed 5.5%. After this 12-month run-out period, PHP will retain 100% of rebate revenue otherwise due to Clackamas County under this agreement.

3. **Exhibit B.** Exhibit B (Service Fees) to the Services Agreement is superseded and replaced in its entirety by the new Exhibit B attached hereto, which shall be effective for the contract renewal term of January 1, 2022 through December 31, 2022.

Capitalized Terms: All capitalized terms in this Amendment shall have the same meaning given to such terms in the Services Agreement unless otherwise specified in this Amendment.

Continuation of Services Agreement: Except as specifically amended pursuant to the foregoing, the Services Agreement shall continue in full force and effect in accordance with the terms in existence as of the date of this Amendment. After the date of this Amendment, any reference to the Services Agreement shall mean the Services Agreement as amended by this Amendment.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date first written above.

By: **Providence Health Plan**

Signature: Brad Garrigues

Name: Bradley J. Garrigues

Title: Chief Sales & Underwriting Officer

Date: 5/13/22

By: **Clackamas County**

Signature: _____

Name: _____

Title: _____

Date: _____

EXHIBIT B: SERVICE FEES

This Exhibit B lists the service fees you must pay us for our services under the Services Agreement for the period of: January 1, 2022 through December 31, 2024.

Core Package of Services	
	Note: PEPM means Per Employee Per Month
Medical Claims Administration	$32.45 PEPM
Pharmacy Claims Administration & Management	$5.41 PEPM
Providence ASO Signature Network	$8.11 PEPM
Medical, Case and Disease Management	$9.37 PEPM
MHCD with Administration, Utilization Management and Network	$0.00 PEPM (included in Medical Claims Administration fee)
Alternative Care/Chiropractic Care Administration & Network (ASH Network; PHP processing)	$2.30 PEPM
Health Coaching – 12 Sessions	$2.12 PEPM
Total Monthly Administrative Fee	**$59.76 PEPM**
Additional Services	
Benefits Administration:	
Fiduciary Fee	Included
Terminal Claims Processing	3 X Fees (one-time fee)
Custom Reporting	$175/hr (minimum charge of $350)
Miscellaneous Consulting	$175/hr (minimum charge of $350)
SPD Printing and Distribution	At Our cost
Ancillary Services:	
HIPAA Administration (HIPAA Cert upon request)	No additional charge
Providence Nurse Advice Line	No additional charge
LifeBalance	No additional charge
TruHearing (available only in OR and SWWA)	No additional charge
ChooseHealthy (available only in OR and SWWA)	No additional charge

0121 to 0122 ASO Contract Comparison – ACA non-grandfathered plans (non-GR)

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

– FINAL 11/16/2021 –

PROVIDENCE Health Plan

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 2022. 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 0121 documents)	New Language & Provisions (in new 0122 documents)	Benefit or Benefit Administ-ration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
Category A: Benefit Changes – For all plan types, except as otherwise denoted								
Universal Newborn Nurse Home Visits	All Handbooks	Addition of newborn nurse home visiting services	**4.8 MATERNITY SERVICES** **** **Covered Services include:** • Prenatal care. • Delivery at an approved facility or birthing center. • Postnatal care, including complications of pregnancy and delivery. • Emergency treatment for complications of pregnancy and unexpected pre-term birth. • Newborn nursery care* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within time frames outlined in Newborn, Newly Adopted Children, and Newly Fostered Children Eligibility and Enrollment, section 8.2.4. *Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit. See section 8.2.4 regarding newborn, newly adopted children, and newly fostered children eligibility and enrollment. *****	**4.8 MATERNITY SERVICES** **** **Covered Services include:** • Prenatal care. • Delivery at an approved facility or birthing center. • Postnatal care, including complications of pregnancy and delivery. • Emergency treatment for complications of pregnancy and unexpected pre-term birth. • Newborn nursery care* Newborn nurse home visits.** *Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit. **Newborn nurse home visits are provided for newborns up to 6 months of age, including foster and newly adopted newborns (if covered by this Plan), for Oregon members residing in a community where the Oregon Health Authority (OHA) Universal Newborn Nurse Home Visiting Program is operating. Newborn nurse home visits are covered without member cost-share (unless required for the Plan to maintain HSA-qualified status) under the newborn's In-Network benefits and must be received from nurses certified by OHA to provide the services. **PLEASE NOTE:** Newborn nursery care, newborn nurse home visits, and any other Services provided to your newborn are covered only when the newborn child is eligible and properly enrolled under this Plan within the time frames outlined in section 8.2.4 regarding Newborn Eligibility and Enrollment. **IMPORTANT NOTE:** Maternity Services for a Member who is serving as a surrogate parent are covered,	Yes	Yes – OR state mandate only (ORS 743A.078 & ORS 433.301); no federal mandate	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. Oregon SB 526 created a new requirement for fully insured plans offered in the state of Oregon (including non-ERISA ASO groups which are required or electively choose to follow state law) to offer and reimburse the cost of nurse home visit services for newborns (including foster and adoptive newborns if applicable) up to 6 months of age. This benefit is available only to Oregon families residing in a community where the Oregon Health Authority (OHA) Universal Newborn Nurse Home Visiting Program operates. Member participation in the Program is strictly voluntary. The coverage must be provided without any cost-sharing, coinsurance, or deductible (except where prohibited for HSA plans). The services are offered through community-level systems of care for families of newborns. It includes between one and three nurse home visits to every family with a newborn beginning at about three weeks of age. Using a tested screening tool, a nurse measures newborn and maternal health and assesses strengths and needs to link the family to community resources.	☑ Yes ☐ No

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				except to the extent that such services are payable under the surrogate parenting contract or agreement.				
			IMPORTANT NOTE: Maternity Services for a Member who is serving as a surrogate parent are covered, except to the extent that such services are payable under the surrogate parenting contract or agreement.					
Foster Children Eligibility	All Handbooks (unless Group already has explicit language in its current handbook re: foster children eligibility)	We are adding explicit language for Groups that currently cover or want to cover foster children under their plan	**8.2.4 Newborn Eligibility and Enrollment** A newborn or adopted child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption as long as enrollment occurs within 60 days from birth or placement and additional Premium, if any, is paid to [Sample Company]. If the enrollment and payment of additional Premium, if any, are not accomplished within this time period, no Services will be covered for the child. Enrollment after this time period may be accomplished as outlined in sections 8.2.3 and 8.3. **4.8 MATERNITY SERVICES** ***** **Covered Services include:** ***** • Newborn nursery care* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within time frames outlined in Newborn, Newly Adopted Children[, and Newly Fostered Children] Eligibility and Enrollment, section 8.2.4. *Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient	**8.2.4 Newborn, Newly Adopted Children, and Newly Fostered Children Eligibility and Enrollment** A newborn, newly adopted child, or newly fostered child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption or foster care as long as enrollment occurs within 60 days of the birth date or placement for adoption or foster care and additional Premium, if any, is paid to [Sample Company]. If the enrollment and payment of additional Premium, if any, are not accomplished within this time period, no Services will be covered for the child. Enrollment after this time period may be accomplished as outlined in sections 8.2.3 and 8.3. **4.8 MATERNITY SERVICES** ***** **Covered Services include:** ***** • Newborn nursery care* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within time frames outlined in Newborn, Newly Adopted Children, and Newly Fostered Children Eligibility and Enrollment, section 8.2.4. *Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit. See section 8.2.4 regarding newborn,	Yes (Only for Groups who are newly adding foster children eligibility now)	No	This change **only applies** to ASO groups that currently cover or wish to start covering foster children as an eligible class of dependents under their plan. (This change does NOT apply to Groups that cover foster children and already have such language in their self-authored SPDs.) For purposes of clarity for members, PHP is recommending that explicit coverage language be added for all ASO groups that currently cover foster children under their plan. PHP is also recommending the adoption of this language for any ASO groups that wish to start covering foster children under their plans. **Note:** There is no requirement for self-funded plans to cover foster children. This change merely serves to explicitly call out such coverage for ASO groups who do offer such coverage.	☐ Yes ☑ No

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			visit benefit. See section 8.2.4 regarding newborn eligibility and enrollment. ***** **8.2.1 Eligibility Date** *** Each Eligible Family Dependent is eligible for coverage on: 4. The date a child is placed with the Subscriber or Spouse for the purpose of adoption by the Subscriber or Spouse. ***** **8.2.3 Eligible Family Dependent Enrollment** You must enroll Eligible Family Dependents on forms provided and/or accepted by [Sample Company]. No Eligible Family Dependent will become a Member until [Sample Company] approves that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within [30 days] after becoming eligible as indicated in section 8.2.1 (see section 8.2.4 regarding newborn and adopted children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 8.3. ***** **8.3.2 New Dependents** If you were eligible to enroll as a Subscriber under this Plan, but did not enroll during a previous enrollment period, and a person becomes your Eligible Family Dependent through marriage, birth, adoption or placement for adoption; the Plan will provide a "special enrollment period" during which you and your Eligible Family Dependent(s) may enroll under this Plan. The "special enrollment period" shall be a period of 30 days and begins on the later of:	newly adopted children, and newly fostered children eligibility and enrollment. ***** **8.2.1 Eligibility Date** *** Each Eligible Family Dependent is eligible for coverage on: 4. The date a child is placed with the Subscriber or Spouse for the purpose of adoption or foster care by the Subscriber or Spouse. ***** **8.2.3 Eligible Family Dependent Enrollment** You must enroll Eligible Family Dependents on forms provided and/or accepted by [Sample Company]. No Eligible Family Dependent will become a Member until [Sample Company] approves that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within [30 days] after becoming eligible as indicated in section 8.2.1 (see section 8.2.4 regarding newborn, newly adopted children, and newly fostered children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 8.3. ***** **8.3.2 New Dependents** If you were eligible to enroll as a Subscriber under this Plan, but did not enroll during a previous enrollment period, and a person becomes your Eligible Family Dependent through marriage, birth, adoption or placement for adoption or foster care; the Plan will provide a "special enrollment period" during which you and your Eligible Family Dependent(s) may enroll under this Plan. The "special enrollment period" shall be a period of 30 days and begins on the later of:				

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			• the date Dependent coverage is made available under this Plan; or • the date of the marriage, birth, or adoption or placement for adoption. ****• in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption; or • in the case of legal guardianship of a Dependent, the date such legal guardianship status begins. ***** **10.1.3 Dependent's Continuation Coverage** A Dependent child who is covered under this Plan has the right to continuation under COBRA if coverage is lost for any of the following qualifying events: • The death of the Subscriber; • The termination of the Subscriber's employment (other than for gross misconduct) or reduction in a Subscriber's hours; • The Subscriber's divorce or legal separation; • Termination of the domestic partnership; • The Subscriber becomes covered under Medicare; or • The child ceases to qualify as an Eligible Family Member under this Plan. A newborn child or a child placed for adoption who is properly enrolled under the terms of this Plan during the COBRA continuation period will be a qualified beneficiary. ***** **15. DEFINITIONS** ***** **Eligible Family Dependent** Eligible Family Dependent means: 1. The legally recognized Spouse or Domestic Partner of a Subscriber; 2. In relation to a Subscriber, the following individuals: a) A biological child, step-child, or legally adopted child[or legally fostered child]; b) An unmarried grandchild for whom the Subscriber or Spouse provides at least 50% support;	• the date Dependent coverage is made available under this Plan; or • the date of the marriage, birth, or adoption or placement for adoption or foster care. ****• in the case of a Dependent's adoption or placement for adoption or foster care, the date of such adoption or placement for adoption or foster care; or • in the case of legal guardianship of a Dependent, the date such legal guardianship status begins. ***** **10.1.3 Dependent's Continuation Coverage** A Dependent child who is covered under this Plan has the right to continuation under COBRA if coverage is lost for any of the following qualifying events: • The death of the Subscriber; • The termination of the Subscriber's employment (other than for gross misconduct) or reduction in a Subscriber's hours; • The Subscriber's divorce or legal separation; • Termination of the domestic partnership; • The Subscriber becomes covered under Medicare; or • The child ceases to qualify as an Eligible Family Member under this Plan. A newborn child or a child placed for adoption or foster care who is properly enrolled under the terms of this Plan during the COBRA continuation period will be a qualified beneficiary. ***** **15. DEFINITIONS** ***** **Eligible Family Dependent** Eligible Family Dependent means: 1. The legally recognized Spouse or Domestic Partner of a Subscriber; 2. In relation to a Subscriber, the following individuals: a) A biological child, step-child, or legally adopted child[or legally fostered child]; b) An unmarried grandchild for whom the Subscriber or Spouse provides at least 50% support;				

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			c) A child placed for adoption with the Subscriber or Spouse; d) An unmarried individual for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support; and e) A child for whom the Subscriber or Spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law. Placement for adoption means the assumption and retention by a Subscriber or Spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption[or foster care]). Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.	c) A child placed for adoption or foster care with the Subscriber or Spouse; d) An unmarried individual for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support; and e) A child for whom the Subscriber or Spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law. Placement for adoption or foster care means the assumption and retention by a Subscriber or Spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child or foster care (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption or foster care). Upon any termination of such legal obligations the placement for adoption or foster care shall be deemed to have terminated.				
Fertility Preservation Services	All Handbooks	Adding coverage for fertility preservation when related to treatment of oncological conditions	N/A **4.14.8 Prescription Drug Exclusions** ***** 4. Drugs used for the treatment of fertility/infertility;	**4.12.19 Fertility Preservation Services** The Plan covers Fertility Preservation where treatment related to cancer conditions may cause irreversible infertility, as recommended by clinical evidence-based guidelines such as those of the National Comprehensive Cancer Network (NCCN) and as outlined in our medical policy. Covered Services include the following: • Office visits, counseling and procedures related to Fertility Preservation; • Retrieval and storage of eggs and sperm; • Drugs related to retrieval and storage of eggs and sperm for Fertility Preservation. Examples include medications used to stimulate the ovaries for oocyte (egg) retrieval. Infertility treatment, including in-vitro fertilization, is NOT covered as part of this benefit. ***** **4.14.8 Prescription Drug Exclusions** ***** 4. Drugs used for the treatment of fertility/infertility, except when used in the treatment of Fertility	Yes	No	For 2022, PHP has elected to cover fertility preservation when related to the treatment of oncologic conditions. This includes male and female fertility preservation, drugs related to egg collection, and collection and storage devices. We are deciding to cover fertility preservation in instances where members are made infertile as a side effect of receiving oncological treatment. **Note:** Acceptance is *optional*, however, PHP recommends adoption for provide a better benefit for certain cancer-afflicted members and to align with medical policy.	☑ Yes ☐ No

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	Edit to exclusions only applies to groups which do not cover infertility services at all		***** **5. EXCLUSIONS** ***** **Exclusions that apply to Reproductive Services:** • All services related to sexual disorders or dysfunctions regardless of gender or cause. This exclusion does not apply to Mental Health Covered Services; • All of the following services related to Infertility: ***** ○ All services and prescription drugs related to fertility preservation; ***** **15. DEFINITIONS** **** N/A	Preservation for oncological conditions as outlined in section 4.12.19; ***** **5. EXCLUSIONS** ***** **Exclusions that apply to Reproductive Services:** • All services related to sexual disorders or dysfunctions regardless of gender or cause. This exclusion does not apply to Mental Health Covered Services; • All of the following services related to Infertility, except as described in section 4.12.19: ***** ○ All services and prescription drugs related to Fertility Preservation; ***** **15. DEFINITIONS** **** **Fertility Preservation** Fertility Preservation means the retrieval and storage of sperm and eggs where treatment of cancer conditions may cause irreversible infertility, as determined by our medical policy.			Edit to exclusions only applies to groups which do not cover infertility services at all	
Gender Dysphoria benefit	All Handbooks (except HSA plans)	Adding definition for Gender Dysphoria Adding language to clarify the Gender Dysphoria benefit includes gender affirming services	**14. DEFINITIONS** **** N/A **** **4.12.13 Gender Dysphoria** Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider	**14. DEFINITIONS** **** **Gender Dysphoria** Gender dysphoria refers to psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity. **** **4.12.13 Gender Dysphoria** Benefits are provided for gender affirming Services for the treatment of Gender Dysphoria as determined by our medical policy. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and select surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For	Yes	Yes WA state mandate only (WA SB 5313); no federal mandate	This WA state mandate is completely **optional** for all ASO groups, whether your self-funded plans are subject to ERISA or not. Adoption of this optional WA state mandate is expected to have an impact on a Group's claim expenses due to the expanded gender dysphoria benefit coverage to include all gender affirming services. In 2021, Washington state enacted the Gender Affirming Treatment Act (SB 5313) which prohibits WA fully insured plans from applying any categorical cosmetic or blanket exclusions to gender affirming treatment when prescribed as medically necessary. "Gender affirming treatment" means a service or product a provider prescribes to an individual to treat any condition related to the individual's	☑ Yes ☐ No

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			surgical benefit and applicable Inpatient or Outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for a list of services requiring Prior Authorization.	example, surgical procedures are subject to your provider surgical benefit and applicable Inpatient or Outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for ~~a list of~~ more information on services requiring Prior Authorization.			gender identity and is prescribed in accordance with generally accepted standards of care. Such treatment includes, but is not limited to, cosmetic services (e.g., facial feminization surgeries), other facial gender affirming treatment (e.g., tracheal shaves, hair electrolysis, or other care (e.g., mastectomies, breast reductions, and breast implants), or any combination of gender affirming procedures, including revisions to prior treatment. Although this is a WA state mandate, PHP has decided to extend this coverage to our Oregon fully insured plans for 2022 for the benefit of our transgender members. However, this change is fully optional for ASO groups (see red note at the top). There is currently no federal mandate for this coverage for self-funded plans.	
Travel transplant benefit	All Handbooks	Update to the Travel Transplant benefit to increase amounts for travel expenses, food, and lodging	**4.13.1 Covered Services** **** Covered Services for transplant recipients include medical Services, Hospital Services, medical supplies, medications and prescription drugs while hospitalized, diagnostic modalities, prosthesis, high dosage chemotherapy for stem cell/bone marrow transplants, and travel expenses. Travel expenses are subject to a $5,000 lifetime benefit maximum for transportation, food and lodging. Food and lodging is subject to a $150 per diem. Per Diem expenses apply to the $5,000 travel expenses lifetime benefit maximum. (Note: Travel Services are not covered for donors.)	**4.13.1 Covered Services** **** Covered Services for transplant recipients include medical Services, Hospital Services, medical supplies, medications and prescription drugs while hospitalized, diagnostic modalities, prosthesis, high dosage chemotherapy for stem cell/bone marrow transplants, and travel expenses. Travel expenses are subject to a $5,000 per transplant benefit maximum for transportation, food and lodging. Food and lodging is subject to a $300 per diem. Per Diem expenses apply to the $5,000 travel expenses per transplant benefit maximum. (Note: Travel Services are not covered for donors.)	Yes	No	For 2022, PHP Is enhancing the benefit for travel expenses related to transplant services from a $5,000 ***lifetime*** benefit maximum to a $5,000 ***per transplant*** benefit maximum, and a $150 per diem limit for food and lodging to a $300 per diem limit. **Note:** Acceptance is *optional*. However, PHP recommends adoption to provide a better benefit for members needing transplant services.	☑ Yes ☐ No

0121 to 0122 ASO Contract Comparison – ACA non-grandfathered plans (non-GR)

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

– FINAL 11/16/2021 –

PROVIDENCE Health Plan

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 2022. 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 0121 documents)	New Language & Provisions (in new 0122 documents)	Benefit or Benefit Administ-ration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
Category B: Benefit Administration Changes – For all plan types, except as otherwise denoted								
Colorectal Cancer Preventive Screening Services	All Handbooks	Updating coverage for Colorectal Cancer Screen Exams from age 50 and older to age 45 and older	**4.1.4 Colorectal Cancer Screening Exams** Benefits for colorectal cancer screening examinations for Members age 50 and older include: **** For Members age 50 and older: • In-Network: All Services for colorectal cancer screenings and exams are covered in full, including prescription drug bowel prep kits as listed in our formulary. • Out-of-Network: All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery Benefit. Fecal occult blood test and double contrast barium enemas are covered under the Lab Services benefit. For Members under age 50: • In-Network and Out-of-Network: All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery Benefit. Fecal occult blood tests and double contrast barium enemas are covered under the Lab Services benefit.	**4.1.4 Colorectal Cancer Screening Exams** Benefits for colorectal cancer screening examinations for Members age 45 and older include: **** For Members age 45 and older: • In-Network: All Services for colorectal cancer screenings and exams are covered in full, including prescription drug bowel prep kits as listed in our formulary. • Out-of-Network: All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery Benefit. Fecal occult blood test and double contrast barium enemas are covered under the Lab Services benefit. For Members under age 45: • In-Network and Out-of-Network: All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery Benefit. Fecal occult blood tests and double contrast barium enemas are covered under the Lab Services benefit.	Yes	Yes	Effective May 2021. the United States Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer in adults aged 45 to 49 years. Before that time, the recommendation was beginning at age 50. This is already a covered ACA preventive service. The change is the age at which colorectal cancer screening exams are covered in full, from age 50 and up to now age 45 and up. All ACA-compliant plans must cover services for adults that have a rating of A or B in the current recommendations of the USPSTF, pursuant to ACA preventive care guidelines. This new preventive service requirement for adults aged 45-49 has a B rating.	
Chiropractic Manipulation and/or Acupuncture benefit	All benefit summaries	Removing dollar limits on these Oregon EHBs as required by ACA	**4.12.9 Chiropractic Manipulation** Coverage is provided for chiropractic manipulation as stated in the Benefit Summary. To be eligible for coverage, all chiropractic manipulation Services must be Medically Necessary and within the Qualified Practitioner's scope of license. **4.12.10 Acupuncture** Coverage is provided for acupuncture as stated in the Benefit Summary. To be eligible for coverage, all acupuncture Services must be Medically Necessary and within the Qualified Practitioner's scope of license.	**4.12.9 Chiropractic Manipulation** Coverage is provided for chiropractic manipulation as stated in the Benefit Summary. To be eligible for coverage, all chiropractic manipulation Services must be Medically Necessary and within the Qualified Practitioner's scope of license. **4.12.10 Acupuncture** Coverage is provided for acupuncture as stated in the Benefit Summary. To be eligible for coverage, all acupuncture Services must be Medically Necessary and within the Qualified Practitioner's scope of license.	Yes	Yes	This change **only applies** to ASO groups that: 1) selected Oregon as its EHB benchmark plan; 2) currently offer a chiropractic manipulation and/or acupuncture benefit; and 3) currently impose annual or lifetime dollar $$ limits on either or both of these benefits. (If you do not meet all 3 criteria above, this contract change does NOT apply to you.) For 2022, Oregon added chiropractic care and acupuncture as essential health benefits (EHBs). Per ACA regulations, self-funded plans are not required to cover any EHBs. But if they do, there can be no annual or lifetime $$ dollar limits	

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				* No handbook change required; change is to benefit summaries only			imposed on any EHBs the self-funded plan chooses to offer. [45 CFR § 147.126] For ASO groups that meet all of the red criteria above, any current annual or lifetime $$ dollar limits (in-network & out-of-network) on your chiropractic and/or acupuncture benefit must be **removed** from your benefit summaries for 2022. Visit limits remain permissible.	
Prescription drug manufactur-er discount and/or copay assistance programs	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	Updating to prescription drug exclusion on manufacturer discounts and/or copay assistance programs	**4.14.1 Using Your Prescription Drug Benefit** ***** • The amount paid by a manufacturer discount and/or copay assistance programs for a brand-name drug when a generic equivalent is available may not 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.	Yes	Yes	Benefit administration change for 2022 on how drug manufacturer discounts and copay assistance programs will apply towards a member's annual limits on cost-sharing. We cannot implement the current exclusion setup nor enforce the exclusion consistently. Under the Final Notice of Benefit and Payment Parameters for 2021, self-funded plans and health insurance issuers have the flexibility to determine whether to include or exclude drug manufacturer coupon amounts or other drug manufacturer direct assistance from an enrollee's annual limitation on cost sharing.	
Amphetami-ne use prescription drug exclusion	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	We are removing amphetamine use as a prescription drug exclusion	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: 1. Drugs or medicines delivered, injected or administered to you by a physician, or other provider or another trained person (see section 4.3.5); 2. Amphetamines and amphetamine derivatives except when used in the treatment of narcolepsy or attention deficit and/or hyperactivity disorder in children and adults;	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: 1. Drugs or medicines delivered, injected or administered to you by a physician, or other provider or another trained person (see section 4.3.5);	Yes	No	We currently do not have a way to enforce this policy and Pharmacy has decided to remove exclusion language and continue with utilization management of amphetamines use.	
Drugs use in treatment of drug induced fatigue exclusion	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	We are removing the prescription drug exclusion regarding drug-induced fatigue,	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 14. Drugs used in the treatment of drug-induced fatigue, general fatigue and idiopathic hypersomnia;	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: *****	Yes	No	PHP has decided to retire this exclusion at the recommendation of our medical directors. There are many factors contributing to fatigue and a blanket exclusion like the one we are removing may prevent some members from receiving the drugs they need. Prescriptions are subject to approval.	

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		general fatigue and idiopathic hypersomnia						
Category C: Language Changes Only – For all plan types, except as otherwise denoted								
Virtual Visits (Telehealth Services)	All Handbooks except Personal Option	Renaming Virtual Visits to Telehealth Services to clearly reflect how PHP and health industry refers to benefit	**1.1 KEY FEATURES OF YOUR [PLAN NAME]** ***** ➢ Some Services are covered only under your In-Network benefits: • Virtual Visits, as specified in section 4.3.2; ***** **3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS / 3.3 SERVICES PROVIDED WITHOUT MEDICAL HOME REFERRAL OR BY OUT-OF-NETWORK PROVIDERS** ***** **Some Services are only covered under your In-Network benefit:** Virtual Visits (see section 4.3.2). ***** --- **4.3.2 Virtual Visits** The Plan provides coverage for Virtual Visits with In-Network Providers using secure internet technology: • Phone and Video Visits: Phone and Video Visits are covered as shown in your Benefit Summary. All Phone and Video Visits must be Medically Necessary and received from In-Network Providers. Not all In-Network Providers are contracted with us to provide Phone and Video Visits. In-Network Providers who are authorized to provide Phone and Video Visits have agreed to use secure internet technology approved by us to protect your information from unauthorized access or release. • Web-direct Visits: Web-direct Visits for common conditions such as cold, flu, sore throat, allergy, earache, sinus pain, or UTI are covered as shown in your Benefit Summary. The Member completes a questionnaire to describe the common condition. The questionnaire is reviewed by an In-Network Provider who makes a diagnosis and sends a treatment plan back to the Member. If needed, a prescription is	**1.1 KEY FEATURES OF YOUR [PLAN NAME]** ***** • Some Services are covered only under your In-Network benefits: • Telehealth Services, as specified in section 4.3.2; ***** **3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS / 3.3 SERVICES PROVIDED WITHOUT MEDICAL HOME REFERRAL OR BY OUT-OF-NETWORK PROVIDERS** ***** **Some Services are only covered under your In-Network benefit:** Telehealth Services (see section 4.3.2). ***** --- **4.3.2 Telehealth Services** Telehealth services are services delivered through a variety of web-based or telecommunication technologies. The plan covers Telehealth services, when medically necessary and generally accepted healthcare practices and standards determine they can be safely and effectively provided using web-based or telecommunication technologies. **4.3.2.1 On-Demand Virtual Visits** Visits using a dedicated branded, web-based platform (such as Providence ExpressCare Virtual) through a tablet, smartphone, or computer for same-day appointments with a healthcare provider. Benefits will apply, as shown in your Benefit Summary. **4.3.2.2 Office Visits Virtually** Scheduled visits with the member's PCP or Specialist using a teleconferencing application such as Zoom. Benefits will apply, as shown in your Benefit Summary. **4.3.2.3 Telemedicine Services**	No	No	This change has no impact on member benefits. We are removing the term "Virtual Visits" since we do not use that term to describe these services anymore, and to reduce member confusion. The term "Virtual Visits" is replaced with the term "Telehealth Services," which is an industry standard. We are also revising language to more clearly describe how Telehealth benefits are administered.	
---	All Handbooks	--- Language changes to align with PHP's administration of benefit						

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			sent to the Member's pharmacy. All Web-direct Visits must be Medically Necessary and received from authorized In-Network Providers.	Telemedicine Services are covered at the applicable benefit level for the Covered Service, as shown in the Benefit Summary, had the Service been received in person provided that the Service: • Is Medically Necessary; • Does not duplicate or supplant a Service that is available to the patient in person; • Is provided by a Qualified Practitioner; • Originates at a qualified site, such as a Hospital, rural health clinic, federally qualified health center, physician's office, community mental health center, skilled nursing facility, renal dialysis center, or public health services center; • Is delivered through a two-way ~~video~~ communication that allows the Qualified Practitioner to interact with the Member receiving the Service who is at an originating site. For Members utilizing Telemedicine Services for the treatment of diabetes where one of the participants is a representative of an academic health center, coverage is provided when Services are delivered through a two-way electronic communication. This includes, but is not limited to, video, audio, Voice over Internet Protocol, or transmission of telemetry, that allows a health professional to interact with the Member, a parent or guardian of a Member or another health professional on a Member's behalf, who is at an originating site. ***** **4.3.4 Telephone visits** Plan covers scheduled audio-only Office Visits for ~~established~~ patients with an In-network Provider ***** **15. DEFINITIONS** The following are definitions of important capitalized terms used in this Member Handbook. ***** **Providence ExpressCare Virtual Visits** Providence ExpressCare Virtual Visits can be utilized for common conditions; such as sore throat, cough, or			Modifying a previously presented language change. We have replaced "Telemedical" with "Telemedicine" to conform with the industry standard language. Removing the word "video" since these services are also provided via audio-only communication.	

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			*****	fever, etc. using Providence's web-based platform through a tablet, smartphone, or computer for same day appointments. Virtual Visits are with In-Network Providers who are contracted with Providence Health Plan to provide Providence ExpressCare Virtual. Benefits will apply, as shown in your Benefit Summary. See section 4.3.2 for more details. *****				
		Telemedical Services moved above to section 4.3.2.3 and replaced with Telephone visits in section 4.3.4	**4.3.4 Telemedical Services** Telemedical Services are covered at the applicable benefit level for the Covered Service, as shown in the Benefit Summary, had the Service been received in person provided that the Service: • Is Medically Necessary; • Does not duplicate or supplant a Service that is available to the patient in person; • Is provided by a Qualified Practitioner; • Originates at a qualified site, such as a Hospital, rural health clinic, federally qualified health center, physician's office, community mental health center, skilled nursing facility, renal dialysis center, or public health services center; and • Is delivered through a two-way video communication that allows the Qualified Practitioner to interact with the Member receiving the Service who is at an originating site. For Members utilizing Telemedical Services for the treatment of diabetes where one of the participants is a representative of an academic health center, coverage is provided when Services are delivered through a two-way electronic communication. This includes, but is not limited to, video, audio, Voice over Internet Protocol, or transmission of telemetry, that allows a health professional to interact with the Member, a parent or guardian of a Member, or another health professional on a Member's behalf, who is at an originating site. *****				Making a corrective edit to a previously presented change that removes the word "established" as it is not a requirement; new patients may also receive these services. This is not a change in benefits and is only a language change.	

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		Updating definitions based on changes above; Adding Providence ExpressCare Virtual Visits definition; Removing Virtual Visits definition as that term is no longer used in section 4.3.2	**15. DEFINITIONS** The following are definitions of important capitalized terms used in this Member Handbook. ***** **Virtual Visit** Virtual Visit means a visit with an In-Network Provider using secure internet technology: • Phone and Video Visit: Phone and Video Visit means a Medically Necessary and appropriate consultation through phone and video with an In-Network Provider using Providence Health Plan approved secure technology. A Phone and Video Visit must relate to the treatment of a covered illness or injury (see also section 4.3.2). • Web-direct Visit: Web-direct Visit means a Medically Necessary consultation with an In-Network Provider utilizing an online questionnaire to collect information and diagnose common conditions such as cold, flu, sore throat, allergy, earache, sinus pain or UTI (see also section 4.3.2).					
Women's Health Care Services	Choice and Connect Handbooks	Adding language to call out that women can self-refer to a women's health care provider	**2.1 [PLAN NAME]** Your [Plan Name] allows you to receive Covered Services from your Medical Home provider or by specialists when referred by your Medical Home Provider through what is called your In-Network benefit. Your In-Network benefit also provides coverage for Services to other In-Network Providers when you access these providers through a Medical Home Referral.	**2.1 [PLAN NAME]** Your [Plan Name] allows you to receive Covered Services from your Medical Home provider or by specialists when referred by your Medical Home Provider through what is called your In-Network benefit. Your In-Network benefit also provides coverage for Services to other In-Network Providers when you access these providers through a Medical Home Referral. A	No	Yes	We are adding language to clarify that a woman can access a women's health care provider without a referral for any type of plan, as required by both federal ACA and state reproductive equity laws. This protects a woman's right to directly access certain health care practitioners for women's health care services.	

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	--- Personal Option, HSA and Option Advantage Handbooks --- All Handbooks		***** **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 also choose 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. ***** --- **3.2.1 Primary Care Providers** A Primary Care Provider is a Qualified Practitioner who specializes in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a physician assistant, when providing services under the supervision of a physician, who agrees to be responsible for the continuing medical care by serving as case manager. Members may also choose a physician specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Primary Care Provider. ***** --- **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. 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	woman can directly access a Women's Health Care Provider without a referral from her designated Medical Home. ***** **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 also choose and self-refer to a physician specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Medical Home Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Medical Home Primary Care Provider. ***** --- **3.2.1 Primary Care Providers** A Primary Care Provider is a Qualified Practitioner who specializes in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a physician assistant, when providing services under the supervision of a physician, who agrees to be responsible for the continuing medical care by serving as case manager. Members may also choose and self-refer to a physician specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Primary Care Provider. ***** --- **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				

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			assistants and advanced registered nurse practitioners specializing in women's health care, certified nurse midwives, and licensed direct entry midwives.	and naturopaths (if they are licensed to provide the services), physician assistants and advanced registered nurse practitioners specializing in women's health care, certified nurse midwives, and licensed direct entry midwives.				
Updating language on HSA Qualified status	HSA Qualified Handbooks	Adding clarification that HSA qualification means that it may be paired with an employer sponsored HSA and HSA status is not automatic with enrollment in the Health Plan Adding detail that plan is disqualified as an HSA Qualified plan if it is provided in conjunction with an HRA Adding reference to section 2.1 from HSA and HDHP definitions for	**2.1 [PLAN NAME]** The coverage under this Plan is Health Savings Account-qualified, which means that this Plan qualifies as a High Deductible Health Plan for use in connection with a Health Savings Account (HSA). ***** Note: should the criteria for federal qualifications on HSA-qualified High Deductible Health Plans be revised or clarified in a way that would result in non-qualification of this Plan, we may initiate an amendment in order to maintain that qualification. ***** **15. DEFINITIONS** ***** **Health Savings Account** Health Savings Account (HSA) means a tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses for you and/or your Family Members (also known as the account beneficiaries) in accordance with Section 223 of the Internal Revenue Code. Account beneficiaries must be enrolled in an HSA-qualified High Deductible Health Plan to contribute to an HSA. ***** **High Deductible Health Plan** High Deductible Health Plan (HDHP) means an HSA-qualified Health Benefit Plan as defined in Section 223 of the Internal Revenue Code that qualifies for use with an HSA.	**2.1 [PLAN NAME]** The coverage under this Plan is Health Savings Account-qualified, which means that this Plan qualifies as a High Deductible Health Plan (HDHP) for use in connection with a Health Savings Account (HSA). Your eligibility for this HDHP means that it may be paired with an employer-sponsored HSA. However, HSA-Qualified plan status is not automatic with enrollment in this HDHP alone. Additional steps are required to pair this Plan with an HSA. ***** Note: should the criteria for federal qualifications on HSA-qualified High Deductible Health Plans be revised or clarified in a way that would result in non-qualification of this Plan, we may initiate an amendment in order to maintain that qualification. This Plan is also disqualified as an HSA-Qualified plan if it is provided alongside a Health Reimbursement Account (HRA). ***** **15. DEFINITIONS** ***** **Health Savings Account** Health Savings Account (HSA) means a tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses for you and/or your Family Members (also known as the account beneficiaries) in accordance with Section 223 of the Internal Revenue Code. Account beneficiaries must be enrolled in an HSA-qualified High Deductible Health Plan to contribute to an HSA. See section 2.1 for more information on HSAs. ***** **High Deductible Health Plan** High Deductible Health Plan (HDHP) means an HSA-qualified Health Benefit Plan as defined in Section 223 of the Internal Revenue Code that qualifies for use with	No	No	PHP is adding information to HSA books to explicitly state that HSA plans that are coupled with a Health Reimbursement Account (HRA) disqualifies the plan as HSA Qualified.	

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		more information		an HSA. See section 2.1 for more information on HDHPs.				
Medical home selection language	Choice and Connect Handbooks	Addition of online resources for medical home selection and rearrangement of options	**3.1.1 Choosing or Changing a Medical Home** ***** Once you have chosen a Medical Home, you must communicate your Medical Home selection to Providence Health Plan before receiving services: • **Phone:** Call Customer Service at 503-574-7500 or 800-878-4445, Monday through Friday, 8 a.m. to 5 p.m. • **Mail:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com/medhomeform. Mail your completed form to: Providence Health Plan Attn: Customer Service PO Box 3125 Portland, OR 97208 • **Email:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com/medhomeform. E-mail your completed form to medicalhomeselectionforms@providence.org. • **Fax:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com/medhomeform. Fax your completed form to 503-574-8208.	**3.1.1 Choosing or Changing a Medical Home** ***** Once you have chosen a Medical Home, you must communicate your Medical Home selection to Providence Health Plan before receiving services: • **Online**: Visit myProvidence to log into your account and select a Medical Home for you or your family* • **Mail**: Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com/medhomeform. Mail your completed form to: Providence Health Plan Attn: Customer Service P.O. Box 4327 Portland, OR 97208-4327 • **Phone:** Call Customer Service at 503-574-7500 or 800-878-4445, Monday through Friday, 8 a.m. to 5 p.m. • **Fax:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com/medhomeform. Fax your completed form to 503-574-8208. *Adults age 18 and over must log into myProvidence separately to select their own medical homes.	No	No	PHP is updating the language on Medical Home selection to help members select their Medical Home more easily. We believe this improvement will decrease call volume and it will also improve consistency across materials.	
		Email option is removed as it is not guaranteed to be secure on the end of the sender						

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Removing list of services requiring prior authorization from handbooks	All Handbooks	Removing list of services requiring prior authorization and directing members to the list on our website	**3.5 PRIOR AUTHORIZATION** ***** **Services requiring Prior Authorization:** • All inpatient admissions to a Hospital (not including emergency room care), Skilled Nursing Facility or a rehabilitation facility, all emergency hospitalizations (we need to be notified within 48 hours, or as soon as reasonably possible) and all Hospital and birthing center admissions for maternity/delivery Services. • All outpatient surgical procedures. • Anesthesia Care with Diagnostic Endoscopy; • All Travel Expense Reimbursement, as provided in section 3.6. • All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services for Mental Health, and Chemical Dependency, as provided in sections 4.10 and 4.10.3. • All Applied Behavior Analysis Services, as provided in section 4.10.2. • All Human Organ/Tissue Transplant Services, as provided in section 4.13. • All Restoration of Head/Facial Structures; Limited Dental Services, as provided in section 4.12.6. • All Temporomandibular Joint (TMJ) Services, as provided in section 4.12.7. • All High Tech Imaging, including PET, CT, CTA, MRI and MRA, Nuclear Cardiac Study Services, and echocardiography Services, as provided in section 4.4.1. • All Sleep Study Services, as provided in section 4.4.2. • Certain Home Health Care Services, as provided in section 4. 11.1. • Certain Hospice Care Services, as provided in section 4.11.2. • Certain Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment, as provided in section 4.9.	**3.5 PRIOR AUTHORIZATION** ***** **Services requiring Prior Authorization:** • A comprehensive list of services and supplies that must be Prior Authorized is available by visiting our website at ProvidenceHealthPlan.com/PriorAuthorization. You may also contact Customer Service to inquire whether a service or supply requires Prior Authorization. You or your Provider should submit Prior Authorization requests by following the instructions on our website. We will not require Prior Authorization for services and supplies that by law do not require Prior Authorization, including Emergency Room services. ***** **4.10.1Mental Health Services** Benefits are provided for Mental Health Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions. Covered Services include diagnostic evaluation, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services. All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services must be Prior Authorized. ***** **4.10.3 Chemical Dependency Services** Benefits are provided for Chemical Dependency Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions. Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential,	No	No	For 2022, PHP is removing the Prior Authorization (PA) list from all handbooks to eliminate the need to maintain and update this list in multiple sources and to reduce the risk of misalignment between these sources as the PA list changes over time. Going forward, our public-facing ProvLink site, which is fully accessible by all PHP members and providers, will become the single source of truth for our PA lists for our ASO groups.	

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			• Certain outpatient services including, but not limited to, neurodevelopmental therapy, neurological testing, and botulinum therapies. • All outpatient hospitalization and anesthesia for dental Services, as provided in section 4.12.6. • All Genetic Testing Services, as provided in section 4.12.1. • Certain Bariatric Surgery Services, as provided in section 4.12.17. • Certain medications, including certain immunizations, received in your Provider's office, as provided in sections 4.3.5 and 4.1.2. • Certain prescription drugs specified in our Formulary, as provided in section 4.14.1. • Certain infused or injected medications that are clinically indicated for administration by a health care professional. • Certain infused Prescription Drugs administered in a hospital-based infusion center, as provided in section 4.7.1. ***** **4.10.1Mental Health Services** Benefits are provided for Mental Health Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions. Covered Services include diagnostic evaluation, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services. All	day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan. Prior Authorization is required for all inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services. ***** **4.12.1 Genetic Testing and Counseling Services** Genetic testing and counseling and are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature. Genetic testing requires Prior Authorization. ***** **4.12.13 Gender Dysphoria** Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and select surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for more information on services requiring Prior Authorization. ***** **15. DEFINITIONS** ***** **Prior Authorization** Prior Authorization or Prior Authorized means a request to Providence Health Plan or their authorizing agent by you or by a Qualified Practitioner regarding a proposed Service, for which Providence Health Plan's prior approval is required. Prior Authorization review will				
		Removing references to specific services being specified in Prior Authorization section as we are removing the list from the Handbooks						

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			inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services must be Prior Authorized as specified in section 3.7. ***** **4.10.3 Chemical Dependency Services** Benefits are provided for Chemical Dependency Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions. Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan. Prior Authorization is required for all inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services, as specified in section 3.7. ***** **4.12.1 Genetic Testing and Counseling Services** Genetic testing and counseling and are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature. Genetic testing requires Prior Authorization as shown in section 3.7. ***** **4.12.13 Gender Dysphoria** Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient	determine if the proposed Service is eligible as a Covered Service or if an individual is a Member at the time of the proposed Service. To facilitate our review of the Prior Authorization request, additional information may be required about the Member's condition and/or the Services requested. Providence Health Plan may also require that a Member receive further evaluation from a Qualified Practitioner of our choosing. Prior Authorization is subject to the terms and provisions of this Plan. More information about Prior Authorizations are shown in section 3.5. ***** **2.1 [PLAN NAME]** Your Medical Home will work with us to Prior Authorize treatment. If you receive Covered Services from Out-of-Network Providers or without a Medical Home Referral, it is your responsibility to make sure the Services are Prior Authorized by Providence Health Plan before treatment is received.				
		Clarifying that "select" surgical procedures are covered, whereas before						

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	Choice and Connect Handbooks	language could be interpreted as ALL surgical procedures	facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for a list of services requiring Prior Authorization. ***** **15. DEFINITIONS** ***** **Prior Authorization** Prior Authorization or Prior Authorized means a request to Providence Health Plan or their authorizing agent by you or by a Qualified Practitioner regarding a proposed Service, for which Providence Health Plan's prior approval is required. Prior Authorization review will determine if the proposed Service is eligible as a Covered Service or if an individual is a Member at the time of the proposed Service. To facilitate our review of the Prior Authorization request, additional information may be required about the Member's condition and/or the Services requested. Providence Health Plan may also require that a Member receive further evaluation from a Qualified Practitioner of our choosing. Prior Authorization is subject to the terms and provisions of this Plan. Services that require Prior Authorization are shown in section 3.5. ***** **2.1 [PLAN NAME]** Your Medical Home will work with us to Prior Authorize treatment. If you receive Covered Services from Out-of-Network Providers or without a Medical Home Referral, it is your responsibility to make sure the Services listed in section 3.5 are Prior Authorized by Providence Health Plan before treatment is received.					
Our Members wording	All Handbooks	Removing use of words "our Members"	**3.8 MEDICALLY NECESSARY SERVICES** We believe our Members are entitled to comprehensive medical care within the standards of good medical practice. Providence Health Plan's medical directors and special committees of In-Network Providers determine which Services are Medically Necessary, as	**3.8 MEDICALLY NECESSARY SERVICES** We believe you are entitled to comprehensive medical care within the standards of good medical practice. Providence Health Plan's medical directors and special committees of In-Network Providers determine which Services are Medically Necessary, as defined in section	No	No	Removing use of "our members" is a PHP marketing initiative. Changing here to stay consistent across all materials.	

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			defined in section 15. Services that do not meet Medically Necessary criteria will not be covered.	15. Services that do not meet Medically Necessary criteria will not be covered.				
Adding eviCore PA language	Groups who use eviCore for Outpatient Rehabilitation PA managem-ent	Adding language that describes PHP uses eviCore for PA of physical therapy and occupational therapy services	**4.7.2 Outpatient Rehabilitative Services** Benefits are included for outpatient physical, occupational and speech therapy Covered Services provided by a physician or licensed/registered therapist, as stated in the Benefit Summary, to restore or improve lost function following illness or injury. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition and are subject to the visit benefit maximum stated in the Benefit Summary. A visit is considered treatment with one provider (e.g., if you see a physical therapist and a speech therapist the same day at the same facility, it counts as two visits as you have received treatment from two providers). Limits do not apply to Mental Health Covered Services. All Services are subject to review for Medical Necessity.	**4.7.2 Outpatient Rehabilitative Services** Benefits are included for outpatient physical, occupational and speech therapy Covered Services provided by a physician or licensed/registered therapist, as stated in the Benefit Summary, to restore or improve lost function following illness or injury. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition and are subject to the visit benefit maximum stated in the Benefit Summary. A visit is considered treatment with one provider (e.g., if you see a physical therapist and a speech therapist the same day at the same facility, it counts as two visits as you have received treatment from two providers). Limits do not apply to Mental Health Covered Services. All Services are subject to review for Medical Necessity. Providers make notifications for outpatient rehabilitation services through an authorizing agent. A notification is the initial request submitted to the authorizing agent to inform Providence Health Plan that you are starting physical therapy and/or occupational therapy services. The authorizing agent determines if the requests are approved or require medical necessity review. For more information, visit our website at ProvidenceHealthPlan.com/OutpatientRehab.	No	No	For ASO groups that currently use eviCore for Prior Authorization of physical therapy and occupational therapy services ONLY. If you do not use eviCore for this purpose, this change does NOT apply to you. We are adding language to state that we use an authorizing agent (eviCore) for PT and OT services, and also adding a link that directs to our website for more information about eviCore. Making a language edit to a previously presented change to clarify this process and specify eviCore as a delegate rather than a TPA.	
Genetic Testing and Counseling Services	All Handbooks	Addition of language to clarify that select genetic testing requires Prior Authorization	**4.12.1 Genetic Testing and Counseling Services** Genetic testing and counseling are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature.	**4.12.1 Genetic Testing and Counseling Services** Genetic testing and counseling are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature. Select genetic testing requires Prior Authorization, for more information see section 3.5.	No	No	Clarifying requirements for certain genetic testing services and directing to the handbook section for Prior Authorization	

0121 to 0122 ASO Contract Comparison – ACA non-grandfathered plans (non-GR)

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

– FINAL 11/16/2021 –

PROVIDENCE Health Plan

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Brand name drug coverage	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	Updating language to explain how brand name drugs may be excluded if a generic exists	**4.14.1 Using Your Prescription Drug Benefit** • If you or your physician chooses a brand-name drug when a generic-equivalent is available, any difference in cost for Prescription Drug Covered Services 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 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	To provide more transparency in how drugs are currently covered and how they will be setup to process in 2022.	
Growth hormone language	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	We are moving the growth hormone language from prescription drug limitations to prescription drug exclusions	**4.14.7 Prescription Drug Limitations** Prescription drug limitations are as follows: ***** 5. Medications, drugs or hormones prescribed to stimulate growth are not covered, except when there is a laboratory-confirmed diagnosis of growth hormone deficiency for children through 18 years of age and when prescribed for the treatment of documented pituitary destruction in adults. ***** **4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: 1. Drugs or medicines delivered, injected or administered to you by a physician, or other provider or another trained person (see section 4.3.5);	**4.14.7 Prescription Drug Limitations** Prescription drug limitations are as follows: ***** ***** **4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: 2. Drugs or medicines delivered, injected or administered to you by a physician, or other provider or another trained person (see section 4.3.5); 3. Medications, drugs or hormones prescribed to stimulate growth, except when there is a laboratory-confirmed diagnosis of growth hormone deficiency for children through 18 years of age and when prescribed for the treatment of documented pituitary destruction in adults;	No	No	The exclusions section is a more suitable section for this language	
Replacement medications	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	Modifying language to explicitly state damaged medications are excluded	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 12. Replacement of lost or stolen medication;	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 12. Replacement of lost, stolen, or damaged medication;	No	No	To provide transparency on the exclusion of replacing damaged medications.	

0121 to 0122 ASO Contract Comparison – ACA non-grandfathered plans (non-GR)

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

– FINAL 11/16/2021 –

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Blister or bubble repackaging	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	Adding language regarding blister or bubble repackaging to prescription drug exclusions	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 13. Replacement of lost or stolen medication;	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 12. Replacement of lost or stolen medication; 13. Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy's standard packaging for the place of service submitted;	No	No	To provide transparency on the exclusion of repackaged medications unless it is the pharmacy's standard packaging.	
Out-of-network pharmacy use	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	We are adding out-of-network pharmacy use to our prescription drug exclusions	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC; and 21. Early refill of eye drops, except when there is a change in directions by your provider, or if synchronizing your prescription refills. This exclusion does not apply to eye drops prescribed for the treatment of glaucoma.	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC; 21. Early refill of eye drops, except when there is a change in directions by your provider, or if synchronizing your prescription refills. This exclusion does not apply to eye drops prescribed for the treatment of glaucoma; and 22. For drugs obtained at in-network pharmacies without using your pharmacy benefit, reimbursement is limited to our in-network contracted rates, except in the case of Urgent/Emergent situations. This means you may not be reimbursed the full cash price you pay to the pharmacy. Drugs obtained from out-of-network pharmacies are not eligible for reimbursement, except in the case of Urgent/Emergent situations.	No	No	To provide transparency on direct member reimbursements and the use of out-of-network pharmacies unless in urgent/emergent situations	
Urgent PA response time	All handbooks	Aligning urgent PA response time language with PHP operational standards	**6.1 CLAIMS PAYMENT** ***** **Claims Involving Prior Authorization and Formulary Exception (Pre-Service Claims)** **For Prior Authorization of services that involve urgent medical conditions:** You and your provider will be notified of Providence Health Plan's decision within 24 hours after the Prior Authorization request is received. If additional information is needed to complete the review, the requesting provider or you will be notified	**6.1 CLAIMS PAYMENT** ***** **Claims Involving Prior Authorization and Formulary Exception (Pre-Service Claims)** **For Prior Authorization of services that involve urgent medical conditions:** You and your provider will be notified of Providence Health Plan's decision within 72 hours after the Prior Authorization request is received. If additional information is needed to complete the review, the requesting provider or you will be notified	No	No	This change **only applies** to ASO groups with traditional ERISA-subject self-funded plans. It does **not** apply to any ASO groups with non-ERISA ASO governmental plans that are either required to or choose to follow state law. Minor language correction to accurately reflect our current and historical operational practice for urgent prior authorization requests. Operationally, PHP has always responded to	

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			within 24 hours after the request is received. The requesting provider or you will then have 48 hours to submit the additional information. The review will then be completed and the requesting provider or you will be notified of Providence Health Plan's decision by the earlier of, (a) 48 hours after the additional information is received or, (b) if no additional information is provided, 48 hours after the additional information was due.	within 24 hours after the request is received. The requesting provider or you will then have 48 hours to submit the additional information. The review will then be completed and the requesting provider or you will be notified of Providence Health Plan's decision by the earlier of, (a) 48 hours after the additional information is received or, (b) if no additional information is provided, 48 hours after the additional information was due.			urgent PA requests within the 72-hour time frame specified by ERISA for traditional ASO self-funded plans. No practical impact to members, no PA claim administration change; this is a corrective handbook language edit only.	
Coordination of Benefits with Medicare	All Handbooks	Adding language for Medicare disabled/ESRD patients	**6.2.7 Coordination with Medicare** In all cases, coordination of benefits with Medicare will conform with federal statutes and regulations. Medicare means Title XVIII of the Social Security Act, as enacted or amended. Medicare eligibility and how This Plan determines benefit limits are affected by disability and employment status. Please contact Customer Service if you have questions. In accordance with the "working aged" provisions of the Medicare Secondary Payer Manual, when the Employer Group's size is less than 20 employees, for Members who are entitled to and enrolled in Medicare Part A, enrollment in Medicare Part B will be assumed and Medicare will be the primary payer and This Plan will coordinate benefits as the secondary payer even if the Medicare-eligible Member has not elected Medicare Part B. When the Employer Group's size is 20 individuals or more, Medicare will be considered the secondary payer if the Member is enrolled in Medicare. Counting individuals for the Employer size: • Employees counted in the Employer size include the total number of nationwide full-time employees, part-time employees, seasonal employees, and partners who work or who are expected to report for work on a particular day. • Those not counted in the Employer size include retirees, COBRA-qualified beneficiaries and	**6.2.7 Coordination with Medicare** In all cases, coordination of benefits with Medicare will conform with federal statutes and regulations. Medicare means Title XVIII of the Social Security Act, as enacted or amended. Medicare eligibility and how This Plan determines benefit limits are affected by disability and employment status. Please contact Customer Service if you have questions. In accordance with the "working aged" provisions of the Medicare Secondary Payer Manual, when the Employer Group's size is less than 20 employees, for Members who are entitled to and enrolled in Medicare Part A, enrollment in Medicare Part B will be assumed and Medicare will be the primary payer and This Plan will coordinate benefits as the secondary payer even if the Medicare-eligible Member has not elected Medicare Part B. When the Employer Group's size is 20 individuals or more, Medicare will be considered the secondary payer if the Member is enrolled in Medicare. Counting individuals for the Employer size: • Employees counted in the Employer size include the total number of nationwide full-time employees, part-time employees, seasonal employees, and partners who work or who are expected to report for work on a particular day. • Those not counted in the Employer size include retirees, COBRA-qualified beneficiaries and	No	No	We are adding a paragraph that explains that the Coordination with Medicare rules may not apply to disabled people under 65 and ESRD patients, and direct members to the Medicare.gov website for more information.	

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			individuals on other continuation options, and self-employed individuals who participate in the Employer's group health plan.	individuals on other continuation options, and self-employed individuals who participate in the Employer's group health plan. **Medicare disabled and end-stage renal disease (ESRD) patients**: The rules above may not apply to disabled people under 65 and ESRD patients enrolled in Medicare; please see the Medicare website, Medicare.gov, for more information.				
Section 7.2.4 External Review	All Handbooks	Bolding the sentence outlining the timeline for release of medical records in the event of an External Review, requires emphasis Per the recent updates to 743B.254 in HB 2046	**7.2.4 External Review** **** If you request an external review you must agree to authorize release of medical records needed by the IRO and submit any additional information to the IRO no later than five days after the appointment of the IRO, or 24 hours in cases of expedited review. The IRO is entirely independent of the Plan and Providence Health Plan and performs its review under a contract with the Oregon Insurance Division. The IRO will notify you and Providence Health Plan of its decision within three days for expedited reviews and within 30 days when not expedited. The Plan and Providence Health Plan agree to be bound by and to comply with the IRO decision when the decision involves, (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care, or (e) an exception to the Plan's prescription drug formulary.	**7.2.4 External Review** **** **If you request an external review you must agree to authorize release of medical records needed by the IRO and submit any additional information to the IRO no later than five days after the appointment of the IRO, or 24 hours in cases of expedited review.** The IRO is entirely independent of the Plan and Providence Health Plan and performs its review under a contract with the Oregon Insurance Division. The IRO will notify you and Providence Health Plan of its decision within three days for expedited reviews and within 30 days when not expedited. **The Plan and Providence Health Plan agree to be bound by and to comply with the IRO decision when the decision involves, (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care, or (e) an exception to the Plan's prescription drug formulary.**	No	Yes	This change **only applies** to non-ERISA ASO governmental plans that are either required to or choose to follow state law. It does **not** apply to any ASO groups with traditional ERISA-subject self-funded plans.	

0121 to 0122 ASO Contract Comparison – ACA grandfathered plans (GR)

Open Option, Personal Option

– FINAL 11/16/2021 –

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) ASO grandfathered plans, as filed with the State of Oregon DFR for plan year 2022. 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 0121 documents)	New Language & Provisions (in new 0122 documents)	Benefit or Benefit Administ-ration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
Category A: Benefit Changes – For all plan types, except as otherwise denoted								
Universal Newborn Nurse Home Visits	All Handbooks	Addition of newborn nurse home visiting services	**4.8 MATERNITY SERVICES** **** **Covered Services include:** • Prenatal care. • Delivery at an approved facility or birthing center. • Postnatal care, including complications of pregnancy and delivery. • Emergency treatment for complications of pregnancy and unexpected pre-term birth. • Newborn nursery care* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within time frames outlined in Newborn, Newly Adopted Children, and Newly Fostered Children Eligibility and Enrollment, section 8.2.4. *Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit. See section 8.2.4 regarding newborn, newly adopted children, and newly fostered children eligibility and enrollment. *****	**4.8 MATERNITY SERVICES** **** **Covered Services include:** • Prenatal care. • Delivery at an approved facility or birthing center. • Postnatal care, including complications of pregnancy and delivery. • Emergency treatment for complications of pregnancy and unexpected pre-term birth. • Newborn nursery care* Newborn nurse home visits.** *Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit. **Newborn nurse home visits are provided for newborns up to 6 months of age, including foster and newly adopted newborns (if covered by this Plan), for Oregon members residing in a community where the Oregon Health Authority (OHA) Universal Newborn Nurse Home Visiting Program is operating. Newborn nurse home visits are covered without member cost-share (unless required for the Plan to maintain HSA-qualified status) under the newborn's In-Network benefits and must be received from nurses certified by OHA to provide the services. **PLEASE NOTE:** Newborn nursery care, newborn nurse home visits, and any other Services provided to your newborn are covered only when the newborn child is eligible and properly enrolled under this Plan within the time frames outlined in section 8.2.4 regarding Newborn Eligibility and Enrollment. **IMPORTANT NOTE:** Maternity Services for a Member who is serving as a surrogate parent are covered, except to the extent that such services are payable under the surrogate parenting contract or agreement.	Yes	Yes – OR state mandate only (ORS 743A.078 & ORS 433.301); no federal mandate	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. Oregon SB 526 created a new requirement for fully insured plans offered in the state of Oregon (including non-ERISA ASO groups which are required or electively choose to follow state law) to offer and reimburse the cost of nurse home visit services for newborns (including foster and adoptive newborns if applicable) up to 6 months of age. This benefit is available only to Oregon families residing in a community where the Oregon Health Authority (OHA) Universal Newborn Nurse Home Visiting Program operates. Member participation in the Program is strictly voluntary. The coverage must be provided without any cost-sharing, coinsurance, or deductible (except where prohibited for HSA plans). The services are offered through community-level systems of care for families of newborns. It includes between one and three nurse home visits to every family with a newborn beginning at about three weeks of age. Using a tested screening tool, a nurse measures newborn and maternal health and assesses strengths and needs to link the family to community resources.	☑ Yes ☐ No

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			IMPORTANT NOTE: Maternity Services for a Member who is serving as a surrogate parent are covered, except to the extent that such services are payable under the surrogate parenting contract or agreement.					
Fertility Preservation Services	All Handbooks	Adding coverage for fertility preservation when related to treatment of oncological conditions	N/A	**4.12.19 Fertility Preservation Services** The Plan covers Fertility Preservation where treatment related to cancer conditions may cause irreversible infertility, as recommended by clinical evidence-based guidelines such as those of the National Comprehensive Cancer Network (NCCN) and as outlined in our medical policy. Covered Services include the following: • Office visits, counseling and procedures related to Fertility Preservation; • Retrieval and storage of eggs and sperm; • Drugs related to retrieval and storage of eggs and sperm for Fertility Preservation. Examples include medications used to stimulate the ovaries for oocyte (egg) retrieval. Infertility treatment, including in-vitro fertilization, is NOT covered as part of this benefit. *****	Yes	No	For 2022, PHP has elected to cover fertility preservation when related to the treatment of oncologic conditions. This includes male and female fertility preservation, drugs related to egg collection, and collection and storage devices. We are deciding to cover fertility preservation in instances where members are made infertile as a side effect of receiving oncological treatment. **Note:** Acceptance is *optional*, however, PHP recommends adoption for provide a better benefit for certain cancer-afflicted members and to align with medical policy.	☑ Yes ☐ No
			4.14.8 Prescription Drug Exclusions ***** 4. Drugs used for the treatment of fertility/infertility;	**4.14.8 Prescription Drug Exclusions** ***** 4. Drugs used for the treatment of fertility/infertility, except when used in the treatment of Fertility Preservation for oncological conditions as outlined in section 4.12.19;				
			***** **5. EXCLUSIONS** ***** **Exclusions that apply to Reproductive Services:**	***** **5. EXCLUSIONS** ***** **Exclusions that apply to Reproductive Services:**				

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	Edit to exclusions only applies to groups which do not cover infertility services at all		• All services related to sexual disorders or dysfunctions regardless of gender or cause. This exclusion does not apply to Mental Health Covered Services; • All of the following services related to Infertility: ***** ○ All services and prescription drugs related to fertility preservation; ***** **15. DEFINITIONS** **** N/A	• All services related to sexual disorders or dysfunctions regardless of gender or cause. This exclusion does not apply to Mental Health Covered Services; • All of the following services related to Infertility, except as described in section 4.12.19: ***** ○ All services and prescription drugs related to Fertility Preservation; ***** **15. DEFINITIONS** **** **Fertility Preservation** Fertility Preservation means the retrieval and storage of sperm and eggs where treatment of cancer conditions may cause irreversible infertility, as determined by our medical policy.			Edit to exclusions only applies to groups which do not cover infertility services at all	
Gender Dysphoria benefit	All Handbooks (except HSA plans)	Adding definition for Gender Dysphoria Adding language to clarify the Gender Dysphoria benefit includes gender affirming services	**15. DEFINITIONS** **** N/A **** **4.12.10 Gender Dysphoria** Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable Inpatient or Outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for a list of services requiring Prior Authorization.	**15. DEFINITIONS** **** **Gender Dysphoria** Gender dysphoria refers to psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity. **** **4.12.10 Gender Dysphoria** Benefits are provided for gender affirming Services for the treatment of Gender Dysphoria as determined by our medical policy. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and select surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable Inpatient or Outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for more information on services requiring Prior Authorization.	Yes	Yes WA state mandate only (WA SB 5313); no federal mandate	This WA state mandate is completely **optional** for all ASO groups, whether your self-funded plans are subject to ERISA or not. Adoption of this optional WA state mandate is expected to have an impact on a Group's claim expenses due to the expanded gender dysphoria benefit coverage to include all gender affirming services. In 2021, Washington state enacted the Gender Affirming Treatment Act (SB 5313) which prohibits WA fully insured plans from applying any categorical cosmetic or blanket exclusions to gender affirming treatment when prescribed as medically necessary. "Gender affirming treatment" means a service or product a provider prescribes to an individual to treat any condition related to the individual's gender identity and is prescribed in accordance with generally accepted standards of care. Such treatment includes, but is not limited to, cosmetic services (e.g., facial feminization surgeries), other facial gender affirming treatment (e.g., tracheal shaves, hair electrolysis, or other care (e.g., mastectomies, breast reductions, and breast implants), or any	☑ Yes ☐ No

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							combination of gender affirming procedures, including revisions to prior treatment. Although this is a WA state mandate, PHP has decided to extend this coverage to our Oregon fully insured plans for 2022 for the benefit of our transgender members. However, this change is fully optional for ASO groups (see red note at the top). There is currently no federal mandate for this coverage for self-funded plans.	
Foster Children Eligibility	All Handbooks (unless Group already has explicit language in its current handbook re: foster children eligibility)	We are adding explicit language for Groups that currently cover or want to cover foster children under their plan	**8.2.4 Newborn Eligibility and Enrollment** A newborn or adopted child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption as long as enrollment occurs within 60 days from birth or placement and additional Premium, if any, is paid to [Sample Company]. If the enrollment and payment of additional Premium, if any, are not accomplished within this time period, no Services will be covered for the child. Enrollment after this time period may be accomplished as outlined in sections 8.2.3 and 8.3. **4.8 MATERNITY SERVICES** ***** **Covered Services include:** ***** • Newborn nursery care* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within time frames outlined in Newborn, Newly Adopted Children[, and Newly Fostered Children] Eligibility and Enrollment, section 8.2.4. *Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level	**8.2.4 Newborn, Newly Adopted Children, and Newly Fostered Children Eligibility and Enrollment** A newborn, newly adopted child, or newly fostered child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption or foster care as long as enrollment occurs within 60 days of the birth date or placement for adoption or foster care and additional Premium, if any, is paid to [Sample Company]. If the enrollment and payment of additional Premium, if any, are not accomplished within this time period, no Services will be covered for the child. Enrollment after this time period may be accomplished as outlined in sections 8.2.3 and 8.3. **4.8 MATERNITY SERVICES** ***** **Covered Services include:** ***** • Newborn nursery care* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within time frames outlined in Newborn, Newly Adopted Children, and Newly Fostered Children Eligibility and Enrollment, section 8.2.4. *Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits	Yes (Only for Groups who are newly adding foster children eligibility now)	No	This change **only applies** to ASO groups that currently cover or wish to start covering foster children as an eligible class of dependents under their plan. (This change does NOT apply to Groups that cover foster children and already have such language in their self-authored SPDs.) For purposes of clarity for members, PHP is recommending that explicit coverage language be added for all ASO groups that currently cover foster children under their plan. PHP is also recommending the adoption of this language for any ASO groups that wish to start covering foster children under their plans. **Note:** There is no requirement for self-funded plans to cover foster children. This change merely serves to explicitly call out such coverage for ASO groups who do offer such coverage.	Yes X No

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			shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit. See section 8.2.4 regarding newborn eligibility and enrollment. ***** **8.2.1 Eligibility Date** *** Each Eligible Family Dependent is eligible for coverage on: 4. The date a child is placed with the Subscriber or Spouse for the purpose of adoption by the Subscriber or Spouse. ***** **8.2.3 Eligible Family Dependent Enrollment** You must enroll Eligible Family Dependents on forms provided and/or accepted by [Sample Company]. No Eligible Family Dependent will become a Member until [Sample Company] approves that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within [30 days] after becoming eligible as indicated in section 8.2.1 (see section 8.2.4 regarding newborn and adopted children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 8.3. ***** **8.3.2 New Dependents** If you were eligible to enroll as a Subscriber under this Plan, but did not enroll during a previous enrollment period, and a person becomes your Eligible Family Dependent through marriage, birth, adoption or placement for adoption; the Plan will provide a "special enrollment period" during which you and your Eligible Family Dependent(s) may enroll under this Plan.	made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit. See section 8.2.4 regarding newborn, newly adopted children, and newly fostered children eligibility and enrollment. ***** **8.2.1 Eligibility Date** *** Each Eligible Family Dependent is eligible for coverage on: 4. The date a child is placed with the Subscriber or Spouse for the purpose of adoption or foster care by the Subscriber or Spouse. ***** **8.2.3 Eligible Family Dependent Enrollment** You must enroll Eligible Family Dependents on forms provided and/or accepted by [Sample Company]. No Eligible Family Dependent will become a Member until [Sample Company] approves that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within [30 days] after becoming eligible as indicated in section 8.2.1 (see section 8.2.4 regarding newborn, newly adopted children, and newly fostered children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 8.3. ***** **8.3.2 New Dependents** If you were eligible to enroll as a Subscriber under this Plan, but did not enroll during a previous enrollment period, and a person becomes your Eligible Family Dependent through marriage, birth, adoption or placement for adoption or foster care; the Plan will provide a "special enrollment period" during which you and your Eligible Family Dependent(s) may enroll under this Plan.				

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			The "special enrollment period" shall be a period of 30 days and begins on the later of: • the date Dependent coverage is made available under this Plan; or • the date of the marriage, birth, or adoption or placement for adoption. ****• in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption; or • in the case of legal guardianship of a Dependent, the date such legal guardianship status begins. ***** **10.1.3 Dependent's Continuation Coverage** A Dependent child who is covered under this Plan has the right to continuation under COBRA if coverage is lost for any of the following qualifying events: • The death of the Subscriber; • The termination of the Subscriber's employment (other than for gross misconduct) or reduction in a Subscriber's hours; • The Subscriber's divorce or legal separation; • Termination of the domestic partnership; • The Subscriber becomes covered under Medicare; or • The child ceases to qualify as an Eligible Family Member under this Plan. A newborn child or a child placed for adoption who is properly enrolled under the terms of this Plan during the COBRA continuation period will be a qualified beneficiary. ***** **15. DEFINITIONS** ***** **Eligible Family Dependent** Eligible Family Dependent means: 1. The legally recognized Spouse or Domestic Partner of a Subscriber; 2. In relation to a Subscriber, the following individuals: a) A biological child, step-child, or legally adopted child[or legally fostered child]; b) An unmarried grandchild for whom the Subscriber or Spouse provides at least 50% support;	The "special enrollment period" shall be a period of 30 days and begins on the later of: • the date Dependent coverage is made available under this Plan; or • the date of the marriage, birth, or adoption or placement for adoption or foster care. ****• in the case of a Dependent's adoption or placement for adoption or foster care, the date of such adoption or placement for adoption or foster care; or • in the case of legal guardianship of a Dependent, the date such legal guardianship status begins. ***** **10.1.3 Dependent's Continuation Coverage** A Dependent child who is covered under this Plan has the right to continuation under COBRA if coverage is lost for any of the following qualifying events: • The death of the Subscriber; • The termination of the Subscriber's employment (other than for gross misconduct) or reduction in a Subscriber's hours; • The Subscriber's divorce or legal separation; • Termination of the domestic partnership; • The Subscriber becomes covered under Medicare; or • The child ceases to qualify as an Eligible Family Member under this Plan. A newborn child or a child placed for adoption or foster care who is properly enrolled under the terms of this Plan during the COBRA continuation period will be a qualified beneficiary. ***** **15. DEFINITIONS** ***** **Eligible Family Dependent** Eligible Family Dependent means: 1. The legally recognized Spouse or Domestic Partner of a Subscriber; 2. In relation to a Subscriber, the following individuals: a) A biological child, step-child, or legally adopted child[or legally fostered child]; b) An unmarried grandchild for whom the Subscriber or Spouse provides at least 50% support;				

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			c) A child placed for adoption with the Subscriber or Spouse; d) An unmarried individual for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support; and e) A child for whom the Subscriber or Spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law. Placement for adoption means the assumption and retention by a Subscriber or Spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption[or foster care]). Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.	c) A child placed for adoption or foster care with the Subscriber or Spouse; d) An unmarried individual for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support; and e) A child for whom the Subscriber or Spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law. Placement for adoption or foster care means the assumption and retention by a Subscriber or Spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child or foster care (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption or foster care). Upon any termination of such legal obligations the placement for adoption or foster care shall be deemed to have terminated.				
Travel transplant benefit	All Handbooks	Update to the Travel Transplant benefit to increase amounts for travel expenses, food, and lodging	**4.13.1 Covered Services** **** Covered Services for transplant recipients include medical Services, Hospital Services, medical supplies, medications and prescription drugs while hospitalized, diagnostic modalities, prosthesis, high dosage chemotherapy for stem cell/bone marrow transplants, and travel expenses. Travel expenses are subject to a $5,000 lifetime benefit maximum for transportation, food and lodging. Food and lodging is subject to a $150 per diem. Per Diem expenses apply to the $5,000 travel expenses lifetime benefit maximum. (Note: Travel Services are not covered for donors.)	**4.13.1 Covered Services** **** Covered Services for transplant recipients include medical Services, Hospital Services, medical supplies, medications and prescription drugs while hospitalized, diagnostic modalities, prosthesis, high dosage chemotherapy for stem cell/bone marrow transplants, and travel expenses. Travel expenses are subject to a $5,000 per transplant benefit maximum for transportation, food and lodging. Food and lodging is subject to a $300 per diem. Per Diem expenses apply to the $5,000 travel expenses per transplant benefit maximum. (Note: Travel Services are not covered for donors.)	Yes	No	For 2022, PHP Is enhancing the benefit for travel expenses related to transplant services from a $5,000 ***lifetime*** benefit maximum to a $5,000 ***per transplant*** benefit maximum, and a $150 per diem limit for food and lodging to a $300 per diem limit. **Note:** Acceptance is *optional*. However, PHP recommends adoption to provide a better benefit for members needing transplant services.	☑ Yes ☐ No

0121 to 0122 ASO Contract Comparison – ACA grandfathered plans (GR)

Open Option, Personal Option

– FINAL 11/16/2021 –

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Category B: Benefit Administration Changes – For all plan types, except as otherwise denoted								
Colorectal Cancer Preventive Screening Services	All Handbooks	Updating coverage for Colorectal Cancer Screen Exams from age 50 and older to age 45 and older	**4.1.4 Colorectal Cancer Screening Exams** Benefits for colorectal cancer screening examinations for Members age 50 and older include: **** For Members age 50 and older: • In-Network: All Services for colorectal cancer screenings and exams are covered in full, including prescription drug bowel prep kits as listed in our formulary. • Out-of-Network: All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery Benefit. Fecal occult blood test and double contrast barium enemas are covered under the Lab Services benefit. For Members under age 50: • In-Network and Out-of-Network: All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery Benefit. Fecal occult blood tests and double contrast barium enemas are covered under the Lab Services benefit.	**4.1.4 Colorectal Cancer Screening Exams** Benefits for colorectal cancer screening examinations for Members age 45 and older include: **** For Members age 45 and older: • In-Network: All Services for colorectal cancer screenings and exams are covered in full, including prescription drug bowel prep kits as listed in our formulary. • Out-of-Network: All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery Benefit. Fecal occult blood test and double contrast barium enemas are covered under the Lab Services benefit. For Members under age 45: • In-Network and Out-of-Network: All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery Benefit. Fecal occult blood tests and double contrast barium enemas are covered under the Lab Services benefit.	Yes	Yes	Effective May 2021. the United States Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer in adults aged 45 to 49 years. Before that time, the recommendation was beginning at age 50. This is already a covered ACA preventive service. The change is the age at which colorectal cancer screening exams are covered in full, from age 50 and up to now age 45 and up. All ACA-compliant plans must cover services for adults that have a rating of A or B in the current recommendations of the USPSTF, pursuant to ACA preventive care guidelines. This new preventive service requirement for adults aged 45-49 has a B rating.	
Chiropractic Manipulation and/or Acupuncture benefit	All benefit summaries	Removing dollar limits on these Oregon EHBs as required by ACA	**4.12.9 Chiropractic Manipulation** Coverage is provided for chiropractic manipulation as stated in the Benefit Summary. To be eligible for coverage, all chiropractic manipulation Services must be Medically Necessary and within the Qualified Practitioner's scope of license. **4.12.10 Acupuncture** Coverage is provided for acupuncture as stated in the Benefit Summary. To be eligible for coverage, all acupuncture Services must be Medically Necessary and within the Qualified Practitioner's scope of license.	**4.12.9 Chiropractic Manipulation** Coverage is provided for chiropractic manipulation as stated in the Benefit Summary. To be eligible for coverage, all chiropractic manipulation Services must be Medically Necessary and within the Qualified Practitioner's scope of license. **4.12.10 Acupuncture** Coverage is provided for acupuncture as stated in the Benefit Summary. To be eligible for coverage, all acupuncture Services must be Medically Necessary and within the Qualified Practitioner's scope of license. * No handbook change required; change is to benefit summaries only	Yes	Yes	This change **only applies** to ASO groups that: 1) selected Oregon as its EHB benchmark plan; 2) currently offer a chiropractic manipulation and/or acupuncture benefit; and 3) currently impose annual or lifetime dollar $$ limits on either or both of these benefits. (If you do not meet all 3 criteria above, this contract change does NOT apply to you.) For 2022, Oregon added chiropractic care and acupuncture as essential health benefits (EHBs). Per ACA regulations, self-funded plans are not required to cover any EHBs. But if they do, there can be no annual or lifetime $$ dollar limits	

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							imposed on any EHBs the self-funded plan chooses to offer. [45 CFR § 147.126] For ASO groups that meet all of the red criteria above, any current annual or lifetime $$ dollar limits (in-network & out-of-network) on your chiropractic and/or acupuncture benefit must be **removed** from your benefit summaries for 2022. Visit limits remain permissible.	
Prescription drug manufactur-er discount and/or copay assistance programs	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	Updating to prescription drug exclusion on manufacturer discounts and/or copay assistance programs	**4.14.1 Using Your Prescription Drug Benefit** ***** • The amount paid by a manufacturer discount and/or copay assistance programs for a brand-name drug when a generic equivalent is available may not 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.	Yes	Yes	Benefit administration change for 2022 on how drug manufacturer discounts and copay assistance programs will apply towards a member's annual limits on cost-sharing. We cannot implement the current exclusion setup nor enforce the exclusion consistently. Under the Final Notice of Benefit and Payment Parameters for 2021, self-funded plans and health insurance issuers have the flexibility to determine whether to include or exclude drug manufacturer coupon amounts or other drug manufacturer direct assistance from an enrollee's annual limitation on cost sharing.	
Amphetami-ne use prescription drug exclusion	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	We are removing amphetamine use as a prescription drug exclusion	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: 1. Drugs or medicines delivered, injected or administered to you by a physician, or other provider or another trained person (see section 4.3.5); 2. Amphetamines and amphetamine derivatives except when used in the treatment of narcolepsy or attention deficit and/or hyperactivity disorder in children and adults;	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: 1. Drugs or medicines delivered, injected or administered to you by a physician, or other provider or another trained person (see section 4.3.5);	Yes	No	We currently do not have a way to enforce this policy and Pharmacy has decided to remove exclusion language and continue with utilization management of amphetamines use.	

0121 to 0122 ASO Contract Comparison – ACA grandfathered plans (GR)

Open Option, Personal Option

– FINAL 11/16/2021 –

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Drugs use in treatment of drug induced fatigue exclusion	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	We are removing the prescription drug exclusion regarding drug-induced fatigue, general fatigue and idiopathic hypersomnia	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 14. Drugs used in the treatment of drug-induced fatigue, general fatigue and idiopathic hypersomnia;	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 14.	Yes	No	PHP has decided to retire this exclusion at the recommendation of our medical directors. There are many factors contributing to fatigue and a blanket exclusion like the one we are removing may prevent some members from receiving the drugs they need. Prescriptions are subject to approval.	
Category C: Language Changes Only – For all plan types, except as otherwise denoted								
Virtual Visits (Telehealth Services)	All Handbooks except Personal Option	Renaming Virtual Visits to Telehealth Services to clearly reflect how PHP and health industry refers to benefit	**1.1 KEY FEATURES OF YOUR [PLAN NAME]** ***** ➢ Some Services are covered only under your In-Network benefits: • Virtual Visits, as specified in section 4.3.2; ***** **3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS / 3.3 SERVICES PROVIDED WITHOUT MEDICAL HOME REFERRAL OR BY OUT-OF-NETWORK PROVIDERS** ***** **Some Services are only covered under your In-Network benefit:** Virtual Visits (see section 4.3.2). ***** --- **4.3.2 Virtual Visits** The Plan provides coverage for Virtual Visits with In-Network Providers using secure internet technology: • Phone and Video Visits: Phone and Video Visits are covered as shown in your Benefit Summary. All Phone and Video Visits must be Medically Necessary and received from In-Network Providers. Not all In-Network Providers are contracted with us to provide Phone and Video Visits. In-Network Providers who are authorized to provide Phone and Video Visits have agreed to use secure internet technology approved by us to protect your information from unauthorized access or release. • Web-direct Visits: Web-direct Visits for common conditions such as cold, flu, sore throat,	**1.1 KEY FEATURES OF YOUR [PLAN NAME]** ***** • Some Services are covered only under your In-Network benefits: • Telehealth Services, as specified in section 4.3.2; ***** **3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS / 3.3 SERVICES PROVIDED WITHOUT MEDICAL HOME REFERRAL OR BY OUT-OF-NETWORK PROVIDERS** ***** **Some Services are only covered under your In-Network benefit:** Telehealth Services (see section 4.3.2). ***** --- **4.3.2 Telehealth Services** Telehealth services are services delivered through a variety of web-based or telecommunication technologies. The plan covers Telehealth services, when medically necessary and generally accepted healthcare practices and standards determine they can be safely and effectively provided using web-based or telecommunication technologies. **4.3.2.1 On-Demand Virtual Visits** Visits using a dedicated branded, web-based platform (such as Providence ExpressCare Virtual) through a tablet, smartphone, or computer for same-day appointments with a healthcare provider. Benefits will apply, as shown in your Benefit Summary.	No	No	This change has no impact on member benefits. We are removing the term "Virtual Visits" since we do not use that term to describe these services anymore, and to reduce member confusion. The term "Virtual Visits" is replaced with the term "Telehealth Services," which is an industry standard. We are also revising language to more clearly describe how Telehealth benefits are administered.	
--- All Handbooks		--- Language changes to align with PHP's administration of benefit						

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			allergy, earache, sinus pain, or UTI are covered as shown in your Benefit Summary. The Member completes a questionnaire to describe the common condition. The questionnaire is reviewed by an In-Network Provider who makes a diagnosis and sends a treatment plan back to the Member. If needed, a prescription is sent to the Member's pharmacy. All Web-direct Visits must be Medically Necessary and received from authorized In-Network Providers.	**4.3.2.2 Office Visits Virtually** Scheduled visits with the member's PCP or Specialist using a teleconferencing application such as Zoom. Benefits will apply, as shown in your Benefit Summary. **4.3.2.3 Telemedicine Services** Telemedicine Services are covered at the applicable benefit level for the Covered Service, as shown in the Benefit Summary, had the Service been received in person provided that the Service: • Is Medically Necessary; • Does not duplicate or supplant a Service that is available to the patient in person; • Is provided by a Qualified Practitioner; • Originates at a qualified site, such as a Hospital, rural health clinic, federally qualified health center, physician's office, community mental health center, skilled nursing facility, renal dialysis center, or public health services center; • Is delivered through a two-way ~~video~~ communication that allows the Qualified Practitioner to interact with the Member receiving the Service who is at an originating site. For Members utilizing Telemedicine Services for the treatment of diabetes where one of the participants is a representative of an academic health center, coverage is provided when Services are delivered through a two-way electronic communication. This includes, but is not limited to, video, audio, Voice over Internet Protocol, or transmission of telemetry, that allows a health professional to interact with the Member, a parent or guardian of a Member or another health professional on a Member's behalf, who is at an originating site. ***** **4.3.4 Telephone visits** Plan covers scheduled audio-only Office Visits for ~~established~~ patients with an In-network Provider ***** **15. DEFINITIONS**			Modifying a previously presented language change. We have replaced "Telemedical" with "Telemedicine" to conform with the industry standard language. Removing the word "video" since these services are also provided via audio-only communication.	

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			*****	The following are definitions of important capitalized terms used in this Member Handbook. ***** **Providence ExpressCare Virtual Visits** Providence ExpressCare Virtual Visits can be utilized for common conditions; such as sore throat, cough, or fever, etc. using Providence's web-based platform through a tablet, smartphone, or computer for same day appointments. Virtual Visits are with In-Network Providers who are contracted with Providence Health Plan to provide Providence ExpressCare Virtual. Benefits will apply, as shown in your Benefit Summary. See section 4.3.2 for more details. *****				
		Telemedical Services moved above to section 4.3.2.3 and replaced with Telephone visits in section 4.3.4	**4.3.4 Telemedical Services** Telemedical Services are covered at the applicable benefit level for the Covered Service, as shown in the Benefit Summary, had the Service been received in person provided that the Service: • Is Medically Necessary; • Does not duplicate or supplant a Service that is available to the patient in person; • Is provided by a Qualified Practitioner; • Originates at a qualified site, such as a Hospital, rural health clinic, federally qualified health center, physician's office, community mental health center, skilled nursing facility, renal dialysis center, or public health services center; and • Is delivered through a two-way video communication that allows the Qualified Practitioner to interact with the Member receiving the Service who is at an originating site. For Members utilizing Telemedical Services for the treatment of diabetes where one of the participants is a representative of an academic health center, coverage is provided when Services are delivered through a two-way electronic communication. This includes, but is not limited to, video, audio, Voice over Internet Protocol, or				Making a corrective edit to a previously presented change that removes the word "established" as it is not a requirement; new patients may also receive these services. This is not a change in benefits and is only a language change.	

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		Updating definitions based on changes above; Adding Providence ExpressCare Virtual Visits definition; Removing Virtual Visits definition as that term is no longer used in section 4.3.2	transmission of telemetry, that allows a health professional to interact with the Member, a parent or guardian of a Member, or another health professional on a Member's behalf, who is at an originating site. ***** **15. DEFINITIONS** The following are definitions of important capitalized terms used in this Member Handbook. ***** **Virtual Visit** Virtual Visit means a visit with an In-Network Provider using secure internet technology: • Phone and Video Visit: Phone and Video Visit means a Medically Necessary and appropriate consultation through phone and video with an In-Network Provider using Providence Health Plan approved secure technology. A Phone and Video Visit must relate to the treatment of a covered illness or injury (see also section 4.3.2). • Web-direct Visit: Web-direct Visit means a Medically Necessary consultation with an In-Network Provider utilizing an online questionnaire to collect information and diagnose common conditions such as cold, flu, sore throat, allergy, earache, sinus pain or UTI (see also section 4.3.2).					
Women's Health Care Services	Personal Option, HSA and Option	Adding language to call out that women can self-refer to a women's	**3.2.1 Primary Care Providers** A Primary Care Provider is a Qualified Practitioner who specializes in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a	**3.2.1 Primary Care Providers** A Primary Care Provider is a Qualified Practitioner who specializes in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a	No	Yes	We are adding language to clarify that a woman can access a women's health care provider without a referral for any type of plan, as required by both federal ACA and state	

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	Advantage Handbooks --- All Handbooks	health care provider	physician assistant, when providing services under the supervision of a physician, who agrees to be responsible for the continuing medical care by serving as case manager. Members may also choose a physician specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Primary Care Provider. ***** --- **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. 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 advanced registered nurse practitioners specializing in women's health care, certified nurse midwives, and licensed direct entry midwives.	physician assistant, when providing services under the supervision of a physician, who agrees to be responsible for the continuing medical care by serving as case manager. Members may also choose and self-refer to a physician specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Primary Care Provider. ***** --- **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 advanced registered nurse practitioners specializing in women's health care, certified nurse midwives, and licensed direct entry midwives.			reproductive equity laws. This protects a woman's right to directly access certain health care practitioners for women's health care services.	
Updating language on HSA Qualified status	HSA Qualified Handbooks	Adding clarification that HSA qualification means that it may be paired with an employer sponsored HSA and HSA status is not automatic with enrollment in the Health Plan Adding detail that plan is disqualified as an HSA Qualified plan if it is provided in	**2.1 [PLAN NAME]** The coverage under this Plan is Health Savings Account-qualified, which means that this Plan qualifies as a High Deductible Health Plan for use in connection with a Health Savings Account (HSA). ***** Note: should the criteria for federal qualifications on HSA-qualified High Deductible Health Plans be revised or clarified in a way that would result in non-qualification of this Plan, we may initiate an amendment in order to maintain that qualification. ***** **15. DEFINITIONS**	**2.1 [PLAN NAME]** The coverage under this Plan is Health Savings Account-qualified, which means that this Plan qualifies as a High Deductible Health Plan (HDHP) for use in connection with a Health Savings Account (HSA). Your eligibility for this HDHP means that it may be paired with an employer-sponsored HSA. However, HSA-Qualified plan status is not automatic with enrollment in this HDHP alone. Additional steps are required to pair this Plan with an HSA. ***** Note: should the criteria for federal qualifications on HSA-qualified High Deductible Health Plans be revised or clarified in a way that would result in non-qualification of this Plan, we may initiate an amendment in order to maintain that qualification. This Plan is also disqualified as an HSA-Qualified plan if it is provided alongside a Health Reimbursement Account (HRA). ***** **15. DEFINITIONS**	No	No	PHP is adding information to HSA books to explicitly state that HSA plans that are coupled with a Health Reimbursement Account (HRA) disqualifies the plan as HSA Qualified.	

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		conjunction with an HRA Adding reference to section 2.1 from HSA and HDHP definitions for more information	***** **Health Savings Account** Health Savings Account (HSA) means a tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses for you and/or your Family Members (also known as the account beneficiaries) in accordance with Section 223 of the Internal Revenue Code. Account beneficiaries must be enrolled in an HSA-qualified High Deductible Health Plan to contribute to an HSA. ***** **High Deductible Health Plan** High Deductible Health Plan (HDHP) means an HSA-qualified Health Benefit Plan as defined in Section 223 of the Internal Revenue Code that qualifies for use with an HSA.	***** **Health Savings Account** Health Savings Account (HSA) means a tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses for you and/or your Family Members (also known as the account beneficiaries) in accordance with Section 223 of the Internal Revenue Code. Account beneficiaries must be enrolled in an HSA-qualified High Deductible Health Plan to contribute to an HSA. See section 2.1 for more information on HSAs. ***** **High Deductible Health Plan** High Deductible Health Plan (HDHP) means an HSA-qualified Health Benefit Plan as defined in Section 223 of the Internal Revenue Code that qualifies for use with an HSA. See section 2.1 for more information on HDHPs.				
Removing list of services requiring prior authorization from handbooks	All Handbooks	Removing list of services requiring prior authorization and directing members to the list on our website	**3.5 PRIOR AUTHORIZATION** ***** **Services requiring Prior Authorization:** • All inpatient admissions to a Hospital (not including emergency room care), Skilled Nursing Facility or a rehabilitation facility, all emergency hospitalizations (we need to be notified within 48 hours, or as soon as reasonably possible) and all Hospital and birthing center admissions for maternity/delivery Services. • All outpatient surgical procedures. • Anesthesia Care with Diagnostic Endoscopy; • All Travel Expense Reimbursement, as provided in section 3.6. • All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services for Mental Health, and Chemical Dependency, as provided in sections 4.10 and 4.10.3. • All Applied Behavior Analysis Services, as provided in section 4.10.2. • All Human Organ/Tissue Transplant Services, as provided in section 4.13. • All Restoration of Head/Facial Structures; Limited Dental Services, as provided in section 4.12.6.	**3.5 PRIOR AUTHORIZATION** ***** **Services requiring Prior Authorization:** • A comprehensive list of services and supplies that must be Prior Authorized is available by visiting our website at ProvidenceHealthPlan.com/PriorAuthorization. You may also contact Customer Service to inquire whether a service or supply requires Prior Authorization. You or your Provider should submit Prior Authorization requests by following the instructions on our website. We will not require Prior Authorization for services and supplies that by law do not require Prior Authorization, including Emergency Room services. ***** **4.10.1Mental Health Services** Benefits are provided for Mental Health Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions. Covered Services include diagnostic evaluation, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive	No	No	For 2022, PHP is removing the Prior Authorization (PA) list from all handbooks to eliminate the need to maintain and update this list in multiple sources and to reduce the risk of misalignment between these sources as the PA list changes over time. Going forward, our public-facing ProvLink site, which is fully accessible by all PHP members and providers, will become the single source of truth for our PA lists for our ASO groups.	

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			• All Temporomandibular Joint (TMJ) Services, as provided in section 4.12.7. • All High Tech Imaging, including PET, CT, CTA, MRI and MRA, Nuclear Cardiac Study Services, and echocardiography Services, as provided in section 4.4.1. • All Sleep Study Services, as provided in section 4.4.2. • Certain Home Health Care Services, as provided in section 4. 11.1. • Certain Hospice Care Services, as provided in section 4.11.2. • Certain Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment, as provided in section 4.9. • Certain outpatient services including, but not limited to, neurodevelopmental therapy, neurological testing, and botulinum therapies. • All outpatient hospitalization and anesthesia for dental Services, as provided in section 4.12.6. • All Genetic Testing Services, as provided in section 4.12.1. • Certain Bariatric Surgery Services, as provided in section 4.12.17. • Certain medications, including certain immunizations, received in your Provider's office, as provided in sections 4.3.5 and 4.1.2. • Certain prescription drugs specified in our Formulary, as provided in section 4.14.1. • Certain infused or injected medications that are clinically indicated for administration by a health care professional. • Certain infused Prescription Drugs administered in a hospital-based infusion center, as provided in section 4.7.1. ***** **4.10.3 Chemical Dependency Services** Benefits are provided for Chemical Dependency Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions. Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan. Prior Authorization is required for all inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services. ***** **4.12.1 Genetic Testing and Counseling Services** Genetic testing and counseling and are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature. Genetic testing requires Prior Authorization. ***** **4.12.13 Gender Dysphoria** Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and select surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. Surgical treatment of Gender Dysphoria				

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		Removing references to specific services being specified in Prior Authorization section as we are removing the list from the Handbooks	**4.10.1Mental Health Services** Benefits are provided for Mental Health Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions. Covered Services include diagnostic evaluation, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services. All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services must be Prior Authorized as specified in section 3.7. ***** **4.10.3 Chemical Dependency Services** Benefits are provided for Chemical Dependency Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions. Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan. Prior Authorization is required for all inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services, as specified in section 3.7. ***** **4.12.1 Genetic Testing and Counseling Services** Genetic testing and counseling and are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are	is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for more information on services requiring Prior Authorization. ***** **15. DEFINITIONS** ***** **Prior Authorization** Prior Authorization or Prior Authorized means a request to Providence Health Plan or their authorizing agent by you or by a Qualified Practitioner regarding a proposed Service, for which Providence Health Plan's prior approval is required. Prior Authorization review will determine if the proposed Service is eligible as a Covered Service or if an individual is a Member at the time of the proposed Service. To facilitate our review of the Prior Authorization request, additional information may be required about the Member's condition and/or the Services requested. Providence Health Plan may also require that a Member receive further evaluation from a Qualified Practitioner of our choosing. Prior Authorization is subject to the terms and provisions of this Plan. More information about Prior Authorizations are shown in section 3.5.				

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		Clarifying that "select" surgical procedures are covered, whereas before language could be interpreted as ALL surgical procedures	corrective or therapeutic in nature. Genetic testing requires Prior Authorization as shown in section 3.7. ***** **4.12.13 Gender Dysphoria** Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for a list of services requiring Prior Authorization. ***** **15. DEFINITIONS** ***** **Prior Authorization** Prior Authorization or Prior Authorized means a request to Providence Health Plan or their authorizing agent by you or by a Qualified Practitioner regarding a proposed Service, for which Providence Health Plan's prior approval is required. Prior Authorization review will determine if the proposed Service is eligible as a Covered Service or if an individual is a Member at the time of the proposed Service. To facilitate our review of the Prior Authorization request, additional information may be required about the Member's condition and/or the Services requested. Providence Health Plan may also require that a Member receive further evaluation from a Qualified Practitioner of our choosing. Prior Authorization is subject to the terms and provisions of this Plan. Services that require Prior Authorization are shown in section 3.5.					

0121 to 0122 ASO Contract Comparison – ACA grandfathered plans (GR)

Open Option, Personal Option

– FINAL 11/16/2021 –

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Our Members wording	All Handbooks	Removing use of words "our Members"	**3.8 MEDICALLY NECESSARY SERVICES** We believe our Members are entitled to comprehensive medical care within the standards of good medical practice. Providence Health Plan's medical directors and special committees of In-Network Providers determine which Services are Medically Necessary, as defined in section 15. Services that do not meet Medically Necessary criteria will not be covered.	**3.8 MEDICALLY NECESSARY SERVICES** We believe you are entitled to comprehensive medical care within the standards of good medical practice. Providence Health Plan's medical directors and special committees of In-Network Providers determine which Services are Medically Necessary, as defined in section 15. Services that do not meet Medically Necessary criteria will not be covered.	No	No	Removing use of "our members" is a PHP marketing initiative. Changing here to stay consistent across all materials.	
Adding eviCore PA language	Groups who use eviCore for Outpatient Rehabilitation PA managem-ent	Adding language that describes PHP uses eviCore for PA of physical therapy and occupational therapy services	**4.7.2 Outpatient Rehabilitative Services** Benefits are included for outpatient physical, occupational and speech therapy Covered Services provided by a physician or licensed/registered therapist, as stated in the Benefit Summary, to restore or improve lost function following illness or injury. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition and are subject to the visit benefit maximum stated in the Benefit Summary. A visit is considered treatment with one provider (e.g., if you see a physical therapist and a speech therapist the same day at the same facility, it counts as two visits as you have received treatment from two providers). Limits do not apply to Mental Health Covered Services. All Services are subject to review for Medical Necessity.	**4.7.2 Outpatient Rehabilitative Services** Benefits are included for outpatient physical, occupational and speech therapy Covered Services provided by a physician or licensed/registered therapist, as stated in the Benefit Summary, to restore or improve lost function following illness or injury. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition and are subject to the visit benefit maximum stated in the Benefit Summary. A visit is considered treatment with one provider (e.g., if you see a physical therapist and a speech therapist the same day at the same facility, it counts as two visits as you have received treatment from two providers). Limits do not apply to Mental Health Covered Services. All Services are subject to review for Medical Necessity. Providers make notifications for outpatient rehabilitation services through an authorizing agent. A notification is the initial request submitted to the authorizing agent to inform Providence Health Plan that you are starting physical therapy and/or occupational therapy services. The authorizing agent determines if the requests are approved or require medical necessity review. For more information, visit our website at ProvidenceHealthPlan.com/OutpatientRehab.	No	No	For ASO groups that currently use eviCore for Prior Authorization of physical therapy and occupational therapy services ONLY. If you do not use eviCore for this purpose, this change does NOT apply to you. We are adding language to state that we use an authorizing agent (eviCore) for PT and OT services, and also adding a link that directs to our website for more information about eviCore. Making edit to previously presented change to clarify this process and specify eviCore as a delegate rather than a TPA.	
Genetic Testing and Counseling Services	All Handbooks	Addition of language to clarify that select genetic testing requires Prior Authorization	**4.12.1 Genetic Testing and Counseling Services** Genetic testing and counseling are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result	**4.12.1 Genetic Testing and Counseling Services** Genetic testing and counseling are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are	No	No	Clarifying requirements for certain genetic testing services and directing to the handbook section for Prior Authorization	

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			in medical interventions and solutions that are corrective or therapeutic in nature.	corrective or therapeutic in nature. Select genetic testing requires Prior Authorization, for more information see section 3.5.				
Brand name drug coverage	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	Updating language to explain how brand name drugs may be excluded if a generic exists	**4.14.1 Using Your Prescription Drug Benefit** • If you or your physician chooses a brand-name drug when a generic-equivalent is available, any difference in cost for Prescription Drug Covered Services 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 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	To provide more transparency in how drugs are currently covered and how they will be setup to process in 2022.	
Growth hormone language	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	We are moving the growth hormone language from prescription drug limitations to prescription drug exclusions	**4.14.7 Prescription Drug Limitations** Prescription drug limitations are as follows: ***** 5. Medications, drugs or hormones prescribed to stimulate growth are not covered, except when there is a laboratory-confirmed diagnosis of growth hormone deficiency for children through 18 years of age and when prescribed for the treatment of documented pituitary destruction in adults. ***** **4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: 1. Drugs or medicines delivered, injected or administered to you by a physician, or other provider or another trained person (see section 4.3.5);	**4.14.7 Prescription Drug Limitations** Prescription drug limitations are as follows: ***** ***** **4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: 2. Drugs or medicines delivered, injected or administered to you by a physician, or other provider or another trained person (see section 4.3.5); 3. Medications, drugs or hormones prescribed to stimulate growth, except when there is a laboratory-confirmed diagnosis of growth hormone deficiency for children through 18 years of age and when prescribed for the treatment of documented pituitary destruction in adults;	No	No	The exclusions section is a more suitable section for this language	
Replacement medications	All Handbooks that use PHP for Pharmacy Benefits	Modifying language to explicitly state damaged medications are excluded	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 12. Replacement of lost or stolen medication;	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 12. Replacement of lost, stolen, or damaged medication;	No	No	To provide transparency on the exclusion of replacing damaged medications.	

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	Managem-ent							
Blister or bubble repackaging	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	Adding language regarding blister or bubble repackaging to prescription drug exclusions	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 13. Replacement of lost or stolen medication;	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 12. Replacement of lost or stolen medication; 13. Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy's standard packaging for the place of service submitted;	No	No	To provide transparency on the exclusion of repackaged medications unless it is the pharmacy's standard packaging.	
Out-of-network pharmacy use	All Handbooks that use PHP for Pharmacy Benefits Managem-ent	We are adding out-of-network pharmacy use to our prescription drug exclusions	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC; and 21. Early refill of eye drops, except when there is a change in directions by your provider, or if synchronizing your prescription refills. This exclusion does not apply to eye drops prescribed for the treatment of glaucoma.	**4.14.8 Prescription Drug Exclusions** In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows: ***** 20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC; 21. Early refill of eye drops, except when there is a change in directions by your provider, or if synchronizing your prescription refills. This exclusion does not apply to eye drops prescribed for the treatment of glaucoma; and 22. For drugs obtained at in-network pharmacies without using your pharmacy benefit, reimbursement is limited to our in-network contracted rates, except in the case of Urgent/Emergent situations. This means you may not be reimbursed the full cash price you pay to the pharmacy. Drugs obtained from out-of-network pharmacies are not eligible for reimbursement, except in the case of Urgent/Emergent situations.	No	No	To provide transparency on direct member reimbursements and the use of out-of-network pharmacies unless in urgent/emergent situations	
Urgent PA response time	All handbooks	Aligning urgent PA response time language with PHP operational standards	**6.1 CLAIMS PAYMENT** ***** **Claims Involving Prior Authorization and Formulary Exception (Pre-Service Claims)** **For Prior Authorization of services that involve urgent medical conditions:** You and your provider will be notified of Providence Health Plan's decision within 24 hours after the Prior Authorization request is received.	**6.1 CLAIMS PAYMENT** ***** **Claims Involving Prior Authorization and Formulary Exception (Pre-Service Claims)** **For Prior Authorization of services that involve urgent medical conditions:** You and your provider will be notified of Providence Health Plan's decision within 72 hours after the Prior Authorization request is received.	No	No	This change **only applies** to ASO groups with traditional ERISA-subject self-funded plans. It does **not** apply to any ASO groups with non-ERISA ASO governmental plans that are either required to or choose to follow state law. Minor language correction to accurately reflect our current and historical operational practice	

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			If additional information is needed to complete the review, the requesting provider or you will be notified within 24 hours after the request is received. The requesting provider or you will then have 48 hours to submit the additional information. The review will then be completed and the requesting provider or you will be notified of Providence Health Plan's decision by the earlier of, (a) 48 hours after the additional information is received or, (b) if no additional information is provided, 48 hours after the additional information was due.	If additional information is needed to complete the review, the requesting provider or you will be notified within 24 hours after the request is received. The requesting provider or you will then have 48 hours to submit the additional information. The review will then be completed and the requesting provider or you will be notified of Providence Health Plan's decision by the earlier of, (a) 48 hours after the additional information is received or, (b) if no additional information is provided, 48 hours after the additional information was due.			for urgent prior authorization requests. Operationally, PHP has always responded to urgent PA requests within the 72-hour time frame specified by ERISA for traditional ASO self-funded plans. No practical impact to members, no PA claim administration change; this is a corrective handbook language edit only.	
Coordination of Benefits with Medicare	All Handbooks	Adding language for Medicare disabled/ESRD patients	**6.2.7 Coordination with Medicare** In all cases, coordination of benefits with Medicare will conform with federal statutes and regulations. Medicare means Title XVIII of the Social Security Act, as enacted or amended. Medicare eligibility and how This Plan determines benefit limits are affected by disability and employment status. Please contact Customer Service if you have questions. In accordance with the "working aged" provisions of the Medicare Secondary Payer Manual, when the Employer Group's size is less than 20 employees, for Members who are entitled to and enrolled in Medicare Part A, enrollment in Medicare Part B will be assumed and Medicare will be the primary payer and This Plan will coordinate benefits as the secondary payer even if the Medicare-eligible Member has not elected Medicare Part B. When the Employer Group's size is 20 individuals or more, Medicare will be considered the secondary payer if the Member is enrolled in Medicare. Counting individuals for the Employer size: • Employees counted in the Employer size include the total number of nationwide full-time employees, part-time employees, seasonal employees, and partners who work or who are expected to report for work on a particular day.	**6.2.7 Coordination with Medicare** In all cases, coordination of benefits with Medicare will conform with federal statutes and regulations. Medicare means Title XVIII of the Social Security Act, as enacted or amended. Medicare eligibility and how This Plan determines benefit limits are affected by disability and employment status. Please contact Customer Service if you have questions. In accordance with the "working aged" provisions of the Medicare Secondary Payer Manual, when the Employer Group's size is less than 20 employees, for Members who are entitled to and enrolled in Medicare Part A, enrollment in Medicare Part B will be assumed and Medicare will be the primary payer and This Plan will coordinate benefits as the secondary payer even if the Medicare-eligible Member has not elected Medicare Part B. When the Employer Group's size is 20 individuals or more, Medicare will be considered the secondary payer if the Member is enrolled in Medicare. Counting individuals for the Employer size: • Employees counted in the Employer size include the total number of nationwide full-time employees, part-time employees, seasonal employees, and partners who work or who are expected to report for work on a particular day.	No	No	We are adding a paragraph that explains that the Coordination with Medicare rules may not apply to disabled people under 65 and ESRD patients, and direct members to the Medicare.gov website for more information.	

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			• Those not counted in the Employer size include retirees, COBRA-qualified beneficiaries and individuals on other continuation options, and self-employed individuals who participate in the Employer's group health plan.	• Those not counted in the Employer size include retirees, COBRA-qualified beneficiaries and individuals on other continuation options, and self-employed individuals who participate in the Employer's group health plan. **Medicare disabled and end-stage renal disease (ESRD) patients**: The rules above may not apply to disabled people under 65 and ESRD patients enrolled in Medicare; please see the Medicare website, Medicare.gov, for more information.				
Section 7.2.4 External Review	All Handbooks	Bolding the sentence outlining the timeline for release of medical records in the event of an External Review, requires emphasis Per the recent updates to 743B.254 in HB 2046	**7.2.4 External Review** **** If you request an external review you must agree to authorize release of medical records needed by the IRO and submit any additional information to the IRO no later than five days after the appointment of the IRO, or 24 hours in cases of expedited review. The IRO is entirely independent of the Plan and Providence Health Plan and performs its review under a contract with the Oregon Insurance Division. The IRO will notify you and Providence Health Plan of its decision within three days for expedited reviews and within 30 days when not expedited. The Plan and Providence Health Plan agree to be bound by and to comply with the IRO decision when the decision involves, (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care, or (e) an exception to the Plan's prescription drug formulary.	**7.2.4 External Review** **** **If you request an external review you must agree to authorize release of medical records needed by the IRO and submit any additional information to the IRO no later than five days after the appointment of the IRO, or 24 hours in cases of expedited review.** The IRO is entirely independent of the Plan and Providence Health Plan and performs its review under a contract with the Oregon Insurance Division. The IRO will notify you and Providence Health Plan of its decision within three days for expedited reviews and within 30 days when not expedited. **The Plan and Providence Health Plan agree to be bound by and to comply with the IRO decision when the decision involves, (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care, or (e) an exception to the Plan's prescription drug formulary.**	No	Yes	This change **only applies** to non-ERISA ASO governmental plans that are either required to or choose to follow state law. It does **not** apply to any ASO groups with traditional ERISA-subject self-funded plans.	Section 7.2.4 External Review

COVER SHEET

☒ New Agreement/Contract

☐ Amendment/Change/Extension to _____

☐ Other _____

Originating County Department: Human Resources

Other party to contract/agreement: Providence Health Plan

Description:

Approval of 2022 Agreements with Providence Health Plan for Administrative Services for Clackamas County's Self-Funded Medical Benefits. Total value is $26,981,400. Funding through contributions and fees paid by county departments, employees, retirees, COBRA beneficiaries, and other agencies contracting with Clackamas County for employee benefits administration. County general funds are not involved.

After recording please return to: Jason Morrill

☐ County Admin

☐ Procurement

If applicable, complete the following:

Board Agenda Date/Item Number: _____