CLACKAMAS COUNTY BOARD OF COUNTY COMMISSIONERS
Policy Session Worksheet

Presentation Date: October 15, 2019 **Approx. Start Time:** 3:00 PM **Approx. Length:** 30 Min

Presentation Title: Benefit Renewals for 2020

Department: Human Resources

Presenters: Kristi Durham, Benefits Manager

Other Invitees: Evelyn Minor-Lawrence, HR Director & Eric Sarha, Asst. HR Director

WHAT ACTION ARE YOU REQUESTING FROM THE BOARD?

HR is seeking formal approval to renew benefit plans with providers for the 2020 calendar year, as well as approval of the 2020 non-represented cost sharing arrangement. Final plan documents are in the process of being prepared by providers. When completed, they will be reviewed and approved by County Counsel prior to submission to the Board for formal adoption at a future business meeting.

EXECUTIVE SUMMARY:

This policy session will update the Board on 2020 benefit plan renewals, including final plan design, language changes, rates, and benefit cost shares.

Medical/Vision:

There are approximately 1600 employees and early retirees enrolled in the General County medical plans. Due to a combination of plan changes the Benefits Review Committee (BRC) made in the 2017 plan year, and have continued to evaluate for the 2018 and 2019 renewal period, as well as fewer large claims during this renewal period, the 2020 Providence renewal rates decreased 1.5%, and the 2020 Kaiser renewal rates increased 5.0%.

The BRC made two minor coverage adjustment to x-ray/lab services and office visit co-pays on the Providence personal option plan for 2020. Avoiding significant changes will allow us to better evaluate the 2017 plan changes over a longer period, as well as develop consistent plan performance data.

There are approximately 500 employees and early retirees enrolled in the Peace Officers Association (POA) medical plans. The POA medical plans experienced a more significant cost increase. The 2020 Providence POA renewal rates increased 10.5%, and the 2020 Kaiser POA renewal rates increased 10.9%.

The POA did not make any plan design changes to the POA medical plans for 2020.

The medical opt-out cash back amount is remaining the same for all groups in 2020.

Dental:

The dental plans experienced rate changes ranging from a decrease of 1.3% to an increase of 11.8%.

The dental opt-out cash back amount is remaining the same for all groups in 2020.

Other Benefits:

There is a 30% rate reduction to the county paid group term life (GTL) insurance.

All other life insurance products (group universal life, accidental death & dismemberment, and dependent term life insurance), short-term and long-term disability plans, long-term care, and the flexible spending account (FSA) admin fee will retain the same rates as 2019.

Represented Employee Cost-Sharing:
Represented employee cost sharing is defined in the collective bargaining agreements (CBA) of each union. Under the AFSCME, EA and FOPPO CBAs, the County pays 95% of the monthly composite premium for each medical plan up to a maximum of 105% of the previous year's County contribution. Under the POA CBA, the County pays 95% of the composite premium rate for Providence medical plans and the employee agrees to pay 5% of the premium costs. However, if the premium increases more than 10% in any one year, the County and the POA employees shall evenly split the increased costs above 10%. The County pays 100% of the premium for POA employees enrolled in the Kaiser medical plan. The County pays 100% of the dental, life and disability premiums and the administrative costs for the flexible spending accounts.

Non-Represented Employee Cost-Sharing:
The current practice for non-represented employees is to provide benefit cost sharing in a similar manner as represented employees so that there is no disincentive to promote into a management or supervisory position and for the County to remain competitive in attracting and retaining employees. Under the current cost sharing method, the County pays 95% and the employee pays 5% of the tiered medical premium and the County pays 100% of the dental, life and disability premiums and the administrative costs for the flexible spending accounts.

FINANCIAL IMPLICATIONS (current year and ongoing):

Is this item in your current budget? ☒ YES ☐ NO

What is the cost?
The estimated fiscal impact for the 2020 plan year based on current enrollment is:

Medical/Vision:	$39,456,716.40 ($85,512.00 increase attributable to BRC plan changes)
Dental:	$ 4,282,692.00
Opt-out cash back:	$ 417,936.00
Group Term Life:	$ 191,527.20
Disability (STD):	$ 265,708.00
FSA Admin Fee:	$ 33,840.00

What is the funding source? Departments, employees and retirees

STRATEGIC PLAN ALIGNMENT:

- How does this item align with your Department's Strategic Business Plan goals?

  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.

- How does this item align with the County's Performance Clackamas goals?

  Build trust through good government.

LEGAL/POLICY REQUIREMENTS:
Adherence to current labor contracts. Statutory requirement to include retirees in benefits risk pool and health plans.

PUBLIC/GOVERNMENTAL PARTICIPATION:
The County Benefits Review Committee met regularly throughout the 2020 renewal period in a series of meetings throughout spring and summer 2019. The Benefits Program, with the assistance of Public & Government Affairs (PGA), continues to revise the successful communication plan used in prior years. Feedback from employees has been very positive, and with minimal changes for 2020, it makes sense to use a successful communication campaign for open enrollment. Benefits has continued to partner with PGA to maintain a strong communications presence regarding benefits.

OPTIONS:
1. Approve 2020 renewals with Providence, Kaiser, Delta Dental, VSP, Metropolitan Life, Standard Insurance and Navia, and move it forward for formal adoption at a future business meeting. Approve 95%/5% cost share of medical premiums and 100% of the premiums for dental, life, and disability plans for non-represented employees.

2. Approve non-represented employee cost sharing arrangement with changes. Approve 2020 renewals with Providence, Kaiser, Delta Dental, VSP, Metropolitan Life, Standard Insurance and Navia and move it forward for formal adoption at a future business meeting.

3. Do not approve 2020 renewals and/or non-represented employee cost sharing arrangement.

RECOMMENDATION:
Staff recommends option 1: Approve 2020 renewals with Providence, Kaiser, Delta Dental, VSP, Metropolitan Life, Standard Insurance and Navia, and move it forward for formal adoption at a future business meeting. Approve 95%/5% cost share of medical premiums and 100% of the premiums for dental, life, and disability plans for non-represented employees.

ATTACHMENTS:
1. 2020 Rate Chart (Exhibit A)
2. Clackamas County General County 2020 Draft Renewal Report (Exhibit B)
3. General County Providence 2020 Plan Language Changes (Exhibit C)
4. General County Kaiser 2020 Plan Language Changes (Exhibit D)
5. General County Delta Dental 2020 Plan Language Changes (Exhibit E)
6. Clackamas County POA 2020 Draft Renewal Report (Exhibit F)
7. POA Providence 2020 Plan Language Changes (Exhibit G)
8. POA Kaiser 2020 Plan Language Changes (Exhibit H)
9. POA Delta Dental 2020 Plan Language Changes (Exhibit I)

SUBMITTED BY:
Division Director/Head Approval _____KD_____
Department Director/Head Approval ____EM-L_____
County Administrator Approval _____LSB_____

For information on this issue or copies of attachments, please contact Kristi Durham @ 503-742-5470

2020	NONREPRESENTED				REPRESENTED				PEACE OFFICERS			
MEDICAL												
	Single	Married	Single w/ Child/ren	Family	Single	Married	Single w/ Child/ren	Family	Single	Married	Single w/ Child/ren	Family
Kaiser												
Employer	658.52	1,317.06	1,185.36	1,975.58	619.84	1,313.04	1,174.40	2,006.22	707.84	1,415.70	1,274.12	2,123.54
Employee	34.66	69.32	62.38	103.98	73.34	73.34	73.34	73.34	-	-	-	-
	693.18	1,386.38	1,247.74	2,079.56	693.18	1,386.38	1,247.74	2,079.56	707.84	1,415.70	1,274.12	2,123.54
Composite Equivalent				1,466.68				1,466.68				1,553.58
Employer							95%	1,393.34				
Employee								73.34				
Providence Personal Option/VSP Vision												
Employer	708.70	1,417.40	1,277.74	2,128.94	666.30	1,412.30	1,265.30	2,161.30	677.50	1,448.50	1,296.50	2,222.50
Employee	37.30	74.60	67.26	112.06	79.70	79.70	79.70	79.70	93.50	93.50	93.50	93.50
	746.00	1,492.00	1,345.00	2,241.00	746.00	1,492.00	1,345.00	2,241.00	771.00	1,542.00	1,390.00	2,316.00
Composite Equivalent				1,594.00				1,594.00				1,870.00
Employer							95%	1,514.30				1,776.50
Employee								79.70				93.50
Providence Open Option/VSP Vision												
Employer	781.84	1,562.74	1,408.84	2,345.54	608.10	1,430.10	1,268.10	2,254.10	725.10	1,548.10	1,386.10	2,374.10
Employee	41.16	82.26	74.16	123.46	214.90	214.90	214.90	214.90	99.90	99.90	99.90	99.90
	823.00	1,645.00	1,483.00	2,469.00	823.00	1,645.00	1,483.00	2,469.00	825.00	1,648.00	1,486.00	2,474.00
Composite Equivalent				1,933.00				1,933.00				1,998.00
Employer							89%	1,718.10				1,898.10
Employee								214.90				99.90
Medical Opt Out - Cash Back	83.00	164.00	148.00	247.00	185.00	185.00	185.00	185.00				
Medical Opt Out - HRA Contribution									176.00	176.00	176.00	176.00

	NONREPRESENTED				REPRESENTED				PEACE OFFICERS			
DENTAL												
Kaiser												
Employer	104.10	206.10	143.66	246.68	104.10	206.10	143.66	246.68	104.10	206.10	143.66	246.68
Employee	-	-	-	-	-	-	-	-	-	-	-	-
	104.10	206.10	143.66	246.68	104.10	206.10	143.66	246.68	104.10	206.10	143.66	246.68
Composite:				190.00				190.00				190.00
MODA Preventive												
Employer	80.00	160.00	115.00	196.00	80.00	160.00	115.00	196.00				
Employee	-	-	-	-	-	-	-	-				
	80.00	160.00	115.00	196.00	80.00	160.00	115.00	196.00				
Composite:				158.00				158.00				
MODA Incentive												-
Employer	91.00	183.00	128.00	220.00	91.00	183.00	128.00	220.00	73.00	143.00	103.00	174.00
Employee	-	-	-	-	-	-	-	-	-	-	-	-
	91.00	183.00	128.00	220.00	91.00	183.00	128.00	220.00	73.00	143.00	103.00	174.00
Composite:				176.00				176.00				147.00
MODA 50%												
Employer	108.17	212.90	147.80	254.94	171.16	200.16	182.16	211.16				
Employee Cash Back	(48.00)	(94.00)	(65.00)	(113.00)	(87.00)	(87.00)	(87.00)	(87.00)				
FICA/PERS	(30.17)	(59.90)	(41.80)	(71.94)	(54.16)	(54.16)	(54.16)	(54.16)				
	30.00	59.00	41.00	70.00	30.00	59.00	41.00	70.00				
Composite:				57.00				57.00				
Dental Opt Out												
Employer	79.17	154.90	107.80	185.94	142.16	142.16	142.16	142.16	142.16	142.16	142.16	142.16
Employee Cash Back	(49.00)	(95.00)	(66.00)	(114.00)	(88.00)	(88.00)	(88.00)	(88.00)	(88.00)	(88.00)	(88.00)	(88.00)
FICA/PERS	(30.17)	(59.90)	(41.80)	(71.94)	(54.16)	(54.16)	(54.16)	(54.16)	(54.16)	(54.16)	(54.16)	(54.16)
EAP												
Employer Paid	$2.50	$2.50	$2.50	$2.50	$2.50	$2.50	$2.50	$2.50	$2.50	$2.50	$2.50	$2.50
WELLNESS												
Employer Paid	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86

	Elected/ Nonrep	Nonrep Housing Authority	EA	HA/EA	DTD	WES	FOPPO	C-COM (Non-Dispatch)	C-COM (Dispatch)	POA
LIFE INSURANCE										
Face Value	$ 150,000	$ 150,000	$ 50,000	$ 50,000	$ 50,000	$ 50,000	$ 75,000	$ 50,000	$ 50,000	$ 75,000
Employer Paid Premium	$22.20	$22.20	$6.80	$6.80	$6.80	$6.80	$10.20	$6.80	$6.80	$10.20
Face Value (Opt Down Coverage)	$ 50,000	$ 50,000								
Employer Premium	$22.88	$22.88								
Employee Cash Back	$ (11.00)	$ (11.00)								
FICA/PERS	$ (4.48)	$ (4.48)								
Premium	$ 7.40	$ 7.40								
$5000 Dependent - Employee Paid	$2.38	$2.38	$2.38	$2.38	$2.38	$2.38	$2.38	$2.38	$2.38	
$2000 Dependent - Employer Paid										$0.38
AD&D - Employee - Employee Paid	$0.040	$0.040	$0.040	$0.040	$0.040	$0.040	$0.040	$0.040	$0.040	$0.040
AD&D - Family - Employee Paid	$0.060	$0.060	$0.060	$0.060	$0.060	$0.060	$0.060	$0.060	$0.060	$0.060
DISABILITY										
Short-Term Rate per $100 Salary	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 0.24
Long-Term Rate per $100 Salary	$ 0.34	$ 0.34	$ 0.34	$ 0.34	$ 0.34	$ 0.34	$ 0.34	$ 0.34	$ 0.34	$ 0.34
Maximum Covered Salary	$ 3,333	$ 3,333	$ 3,333	$ 3,333	$ 3,333	$ 3,333	$ 3,333	$ 3,333	$ 3,333	$ 3,333
Employee Paid Buy-Up Max Salary	$ 8,333	$ 8,333	$ 8,333	$ 8,333	$ 8,333	$ 8,333	$ 8,333	$ 8,333	$ 8,333	$ 10,000
DEFERRED COMPENSATION										
Employer Paid	6.27%						1.00%	1-3% Match	1-3% Match	4.00%
PERS/OPSRP PENSION										
Employee Rate - County Paid	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%
Employer Rate - PERS Tier 1 & 2	27.07%	25.27%	27.07%	25.27%	27.07%	27.07%	27.07%	27.07%	27.07%	27.07%
OPSRP General Service	19.22%	17.75%	19.22%	17.75%	19.22%	19.22%	19.22%	19.22%	19.22%	19.22%
OPSRP Police & Fire	23.85%						23.85%			23.85%
FICA										
Social Security	6.20%	6.20%	6.20%	6.20%	6.20%	6.20%	6.20%	6.20%	6.20%	6.20%
Medicare	1.45%	1.45%	1.45%	1.45%	1.45%	1.45%	1.45%	1.45%	1.45%	1.45%
RETIREE MEDICAL FUND										
Employer Paid - % of Base Salary	3.50%	(Sheriff's Office Employees Only - POA Union)								
	3.50%	(Sheriff's Office Employees Only - Command)								

	Elected/ Nonrep	Nonrep Housing Authority	EA	HA/EA	DTD	WES	FOPPO	C-COM (Non-Dispatch)	C-COM (Dispatch)	POA
LONGEVITY										
5 - 9 Years	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	$ 67.32
10-14 Years	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	$ 134.64
15-19 Years	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	$ 201.96
20-24 Years	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	$ 269.28
25-30 Years	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.0%	3.0%	3.0%	$ 336.60
30+ Years	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	3.5%	3.5%	3.5%	$ 403.92
VACATION ACCRUALS (MONTHLY)**										
< 5 Years	12.7	12.7	8.7	8.7	8.7	8.7	8.7	10.7	19.1	11.7
Annual Maximum Carryover	280	280	250	250	250	218	280	240	240	240
5 - 9 Years	14.0	14.0	10.7	10.7	10.7	10.7	10.7	12.7	21.1	13.7
Annual Maximum Carryover	280	280	250	250	250	218	280	240	240	240
10-14 Years	16.0	16.0	12.7	12.7	12.7	12.7	12.7	14.7	23.1	15.7
Annual Maximum Carryover	280	280	250	250	250	258	280	280	280	320
15-19 Years	18.0	18.0	14.7	14.7	14.7	14.7	14.7	16.0	24.4	17.0
Annual Maximum Carryover	280	280	250	250	250	258	280	280	280	320
20+ Years	19.3	19.3	16.7	16.7	16.7	16.7	16.7	16.7	25.1	18.3
Annual Maximum Carryover	280	280	250	250	250	258	280	280	280	360
VACATION SELLBACK ACCRUALS (MONTHLY)**										
Accrual (all years of service)	16	16	12	12	12	12	12			
Annual Maximum Carryover	280	280	250	250	250	250	250			
SICK LEAVE										
Monthly accrual	8	8	8	8	8	8	8	8	8	8
No Maximum Carryover										
HOLIDAYS										
Regular	9	9	9	9	9	9	9	9	0	9
Personal (Floating Holiday)	1	1	1	1	1	1	2	1	0	2

Note: Elected Officials do not receive longevity pay, nor do they accrue vacation, sick leave or Personal Holidays.

**Employees hired prior to 01/01/01 have a choice between the regular Vacation plan and the Vacation Sell Back plan.
Employees hired on or after 01/01/01 are enrolled in the Vacation Sell Back plan (except CCOM & POA).
Employees may sell one week of vacation each calendar year as long as they have taken at least one week of vacation during that year.
CCOM Dispatch employees earn additional vacation time in lieu of most holidays.

MERCER
MAKE TOMORROW, TODAY

2020 HEALTH AND WELFARE BENEFIT PLAN PRELIMINARY RENEWAL REPORT

CLACKAMAS COUNTY

SEPTEMBER 2019

GENERAL COUNTY

EXHIBIT: B
PAGE: 1

MARSH & McLENNAN COMPANIES

1

Summary

The Clackamas County General County 2020 health and welfare benefit plans renewal decisions are outlined in this report.

The table on the following pages is a summary of renewal rates by plan for the General County plans.

PLAN	2019 BUDGET RATE	2020 RENEWAL	% INCREASE
Active / Retiree Medical*			
General County			
VALUE: Kaiser HMO Option 10/10/1000 $250 Deductible; Vision $250/12 months			
EE	$660.18	$693.18	5.0%
EE, SP	1,320.36	1,386.38	5.0%
EE, CH	1,188.32	1,247.74	5.0%
EE, FAM	1,980.56	2,079.56	5.0%
COMPOSITE	$1,402.12	1,466.68	4.6%
BASE: PHP Personal Option 20/20/3000 $1000 Common Deductible (includes VSP vision)			
EE	$751.00	$746.00	-0.7%
EE, SP	1,501.00	1,492.00	-0.6%
EE, CH	1,353.00	1,345.00	-0.6%
EE, FAM	2,255.00	2,241.00	-0.6%
COMPOSITE	$1,605.00	1,594.00	-0.7%
BUY-UP: PHP Open Option 20/10/30/2500 $750 Common Deductible (includes VSP vision)			
EE	$835.00	$823.00	-1.4%
EE, SP	1,669.00	1,645.00	-1.4%
EE, CH	1,505.00	1,483.00	-1.5%
EE, FAM	2,506.00	2,469.00	-1.5%
COMPOSITE	$1,902.00	1,933.00	1.6%
Retiree / Temporary Medical			
PHP $1000 Deductible			
EE	$741.76	$730.63	-1.5%
EE, SP	1,483.62	$1,461.36	-1.5%
EE, CH	1,335.16	$1,315.14	-1.5%
EE, FAM	2,225.30	$2,191.92	-1.5%
Kaiser $1000 Deductible - General County			
EE	$508.42	$533.84	5.0%
EE, SP	1,016.84	$1,067.68	5.0%
EE, CH	915.16	$960.90	5.0%
EE, FAM	1,525.32	$1,601.56	5.0%
PHP Medicare Align			
General County	$331.80		-100.0%
Kaiser Medicare			
General County	$391.18	$398.54	1.9%

Vision (VSP) – Rates and Contributions combined with Medical

General County: VSP 12/12/12; $10/$30 copay; $130/$70 allowance			
EE	$7.00	$7.00	0.0%
EE, SP	13.96	13.96	0.0%
EE, CH	14.96	14.96	0.0%
EE, FAM	23.88	23.88	0.0%
COMPOSITE	$17.00	$17.00	0.0%

Dental (Delta Dental of Oregon) – Rates paid 100% by Clackamas County

General County: Delta Dental Incentive			
EE	$91.00	$91.00	0.0%
EE, SP	184.00	183.00	-0.5%
EE, CH	129.00	128.00	-0.8%
EE, FAM	221.00	220.00	-0.5%
COMPOSITE	$170.00	$176.00	3.5%
General County: Delta Dental Constant (50%)			
EE	$28.00	$30.00	7.1%
EE, SP	56.00	59.00	5.4%
EE, CH	39.00	41.00	5.1%
EE, FAM	66.00	70.00	6.1%
COMPOSITE	$51.00	$57.00	11.8%
General County: Delta Dental Preventive			
EE	$82.00	$80.00	-2.4%
EE, SP	164.00	160.00	-2.4%
EE, CH	118.00	115.00	-2.5%
EE, FAM	200.00	196.00	-2.0%
COMPOSITE	$159.00	$158.00	-0.6%
General County/POA: Kaiser			
EE	$103.08	$104.10	1.0%
EE, SP	204.08	206.10	1.0%
EE, CH	142.24	143.66	1.0%
EE, FAM	244.26	246.68	1.0%
COMPOSITE	$188.00	$190.00	1.1%

Life and AD&D (MetLife)			
Basic Life (Rate per $1,000 benefit)			
Nonrepresented – GC	$0.212	$0.148	-30.2%
Represented – GC & POA	$0.196	$0.136	-30.6%
Group Universal Life			
General County and POA	Age Rated	Age Rated	0.0%
Dependent Life per Employee (Rate per Family)			
$5,000 per Dependent – GC	$2.38	$2.38	0.0%
Voluntary AD&D – General County Only (Rate per $1,000 benefit)			
Employee Only	$0.04	$0.04	0.0%
Employee and Family	$0.06	$0.06	0.0%
LTD (Standard)			
Self Insured – General County			
Funding Rate (Per $100 of Covered Salary)	$0.24	$0.24	0.0%
General Fee (PEPM)	$0.36	$0.36	0.0%
New Claim Fee (Per Claim)	$390.00	$390.00	0.0%
Open Claim Fee (Per Claim)	$19.00	$19.00	0.0%
Fully Insured – General County			
Base Plan (Per $100 of Covered Salary)	$0.34	$0.34	0.0%
Buy-Up Plan (Per $100 of Covered Salary)	$0.34	$0.34	0.0%
Employee Assistance Program – EAP			
Cascade (Previously with Standard)			
General Fee PEPM	$2.50	$2.50	0.0%
Flexible Spending Account			
Navia			
Monthly Fee PPPM	$5.00	$5.00	0.0%
Long Term Care – LTC			
Unum – General County			
General Fee PEPM	Age Rated	Age Rated	0.0%

**Rates include the standard 2020 contract changes.*

PEPM = Per Employee Per Month
PMPM = Per Member Per Month
PPPM = Per Participant Per Month

2

Medical/Prescription Drug/Vision/Alternative Care Plans

Self-Funded Plans

The 2020 projection for the Open and Personal Options called for an overall 1.5% decrease for the General County.

The 2020 Providence ASO fees are shown below as per employee per month (PEPM).

Providence Health Plan Administrative Fees

	2020 PEPM
Medical Administration	$27.50
Pharmacy Administration	5.27
Alternative Care Administration	2.24
MH/CD Administration	4.94
Case and Disease Management	9.12
Network Access Fee	8.38
Health Coaching – 12 Sessions	2.06
	$59.51

Stop Loss Administrative Fees – Optum Health

The 2020 stop loss fee has not been finalized at this time. It will be finalized by no later than the end of November. The current specific attachment point is $200,000.

Mercer's underwriting projection for the 2020 renewal is included in **Exhibit A** for reference.

General County

The BRC elected the following plan changes for the 2020 plan year:

Personal Option (Base)

1. Increase Lab & X-Ray coinsurance from 90% to 100%
2. Decrease all office visit copays from $25 to $20

Exhibit B contains the required 2020 contract changes summary for non-grandfathered plans, which was provided by Providence. These will be effective January 1, 2020.

See **Exhibit C** for the Providence 2020 General County benefit summaries.

Retirees – General County

Early (pre-age 65) retirees are eligible for the Providence Personal and Open Option active employee plans.

For those early retirees who live outside of the Providence service area, the County offers the Traditional Option plan for medical coverage. These early retiree rates and prescription drug benefits are the same as the Open Option plans for active employees.

Open Option 15/30/50/2000 $1000 Common Deductible
The County elected no plan changes for the 2020 plan year. The 2020 benefit summary is included in **Exhibit C**.

Providence Fully-Insured Medicare Align Plan (Medicare Eligible)
The 2020 premium rate for the Providence Medicare Align plan has not been received yet.

Medicare Align Plan

Medicare Align With Prescription Drug

Exhibit B contains the standard 2020 contract changes non-grandfathered plans proposed by Providence.

See **Exhibit C** for the Providence 2020 early retiree benefit summaries.

Kaiser Permanente

General County

Kaiser proposed an overall 5.0% increase to the 2019 premium rates.

General County

The General County did not elect to make benefit changes to this plan.

Kaiser's underwriting worksheets for their renewal calculations are included in **Exhibit D** for reference.

Exhibit E contains the 2020 contract changes provided by Kaiser. The BRC accepted the proposed 2020 benefit and administrative clarifications.

See **Exhibit F** for the Kaiser 2020 benefit summaries.

Retirees – General County

Early (pre-age 65) retirees are eligible for the active employee HMO plan. The County also offers a $1000 deductible plan for early retirees and COBRA participants. The proposed rate increase of 5.0% for the General County was accepted by the County.

Medicare-Eligible retirees (age 65 and over) are eligible for the Medicare Supplement plan. Premium rates increased by 1.9% for the General County plans.

Exhibit E contains the 2020 contract changes provided by Kaiser.

See **Exhibit F** for the Kaiser 2020 benefit summaries.

Vision Plans

Vision Service Plan (VSP)

The County elected to renew their vision plans with VSP. The rates for the 2020 plan year are provided in Section 1.

The VSP plans are entering the second year of a two-year rate guarantee. The plan will next renew January 1, 2021.

See **Exhibit G** for the 2020 VSP benefit summaries.

Dental Plans

Delta Dental of Oregon

The Incentive Plan is available to all employees. The 50 Percent Plan and Preventive Plan are only available to General County employees. All three plans are self-funded and administered by Delta Dental of Oregon (Delta).

Delta proposed a three-year administrative fee agreement. The fee will increase by $0.06 PEPM effective January 1, 2020 and by $0.07 PEPM each of the next two renewals. The 2020 administration fee will be as follows:

Rates per Employee per Month	2019	2020	2021	2022
Administration fee	$6.49	$6.55	$6.62	$6.69
% Change		0.9%	1.0%	1.0%

The BRC elected the following dental plan changes for the 2020 plan year:

1. Interim caries arresting medicament application is covered twice per tooth per benefit year
2. Osseous surgery is limited to 2 quadrants per date of service
3. A separate charge for post-operative care done within 30 days following oral surgery is not covered

Exhibit I contains the Delta administrative contract changes for 2020 for General County.

See **Exhibit J** for the 2020 Delta benefit summaries.

Underwriting

Mercer projected a 2020 combined funding decrease of -1.8% for the 2020 self-insured dental plans. The County elects to apply the individual plan funding adjustments to each plan. The break out of adjustments used for the 2020 plan year is provided in the underwriting calculation in **Exhibit H**.

Projections for the County's self-funded dental plans were based on 12 months of claims experience from July 1, 2018, through June 30, 2019. An annual trend factor of 5.0% and 3% margin were used.

Mercer recommended and the County accepted the 2020 funding rates provided in Section 1.

Kaiser Permanente

The County has a fully insured dental plan through Kaiser that is available to all employees. Kaiser proposed a 1.0% rate increase to the 2019 premium rates.

Exhibit E contains the 2020 standard contract changes provided by Kaiser, which will be effective January 1, 2020. See **Exhibit F** for the Kaiser 2020 benefit summaries.

The 2020 premium rates for Kaiser dental plan are shown in Section 1.

Life and Voluntary AD&D Insurance

MetLife

The County has basic life, AD&D, dependent life, and group universal life plans with MetLife. Mercer was able to negotiate a 30% decrease to the basic life rates. All other lines of coverage will receive no increase. The rates are effective through December 31, 2021.

A summary of the rates effective January 1, 2020, through December 31, 2021, are as follows:

General County

Basic Life[1]	
Non-Represented Employees	$0.148/$1,000
Represented Employees	$0.136/$1,000
Dependent Life	
$5,000 per spouse/domestic partner or child	$2.38 PEPM
Voluntary Accidental Death and Dismemberment	
Employee	$0.040/$1,000
Employee and Family (spouse/domestic partner or child)	$0.060/$1,000

[1]*Effective 1/1/20.*

General County

Group Universal Life (Rates Per $1,000)		
Age	**Non-Smoker Rates**	**Smoker Rates**
< 30	$0.044	$0.066
30-34	0.048	0.074
35-39	0.062	0.102
40-44	0.096	0.150
45-49	0.164	0.224
50-54	0.270	0.330
55-59	0.424	0.518
60-64	0.640	0.798
65-69	1.186	1.270
70-74	1.986	1.986

The following levels and corresponding premium rates apply to covered dependent children:

Coverage Amount	$2,000	$4,000	$6,000	$8,000	$10,000
Monthly Rate	$0.12	$0.24	$0.36	$0.48	$0.60

Long Term Disability Insurance

The Standard

The County offers two LTD plans through The Standard as follows:

- **Base LTD Plan**
  - This coverage is provided by the County without contribution from employees. The disability benefit is 60% of the first $3,333 of monthly pre-disability income. The plan is self-funded for the first 180 days of a disability and is fully insured starting on the 181st day of a disability.

- **Buy-up LTD Plan**
  - **General County.** This plan offers General County employees the option of buying additional disability coverage, equal to 60% of the next $5,000 of monthly pre-disability earnings above $3,333 up to a maximum of $8,333.

The buy-up LTD benefit plan for the General County are 100% paid by employees on a pretax basis. The Plans have two funding components – self-funded and fully insured. Both components are administered by The Standard.

The benefits will remain unchanged for the 2020 plan year.

Fees and Premium Rates

The County is in the second year of a two-year rate guarantee with Standard. The next renewal will be January 1, 2021.

The 2020 funding, premium, and fees are as follows:

Self-Insured Plan	
Funding	$0.24 per $100 of covered payroll
Administration Fees	
General	$0.36 PEPM
New Claim	$390 per claim
Open Claim	$19 per open claim at month end
Incidental	As incurred
Insured Plan	
Base – General County	$0.34/$100
Buy-Up – General County	$0.34/$100

Employee Assistance Plan

Cascade Centers

The 2020 fee for EAP services is as follows:

Fee per Participant per Month	
Employee Assistance Program	$2.50

Flexible Spending Account Administrator

Navia Benefits Solutions

The County uses Navia Benefits Solutions (Navia), formerly Flex-Plan Services, to provide FSA plans. The County is entering the third year of a three year rate guarantee with Navia effective through December 31, 2020.

The 2020 fees remain the same as the 2019 fees, as follows:

Fees per Participant per Month	
Health Care FSA	$5.00
Annual Maximum	$2,500
Dependent Care FSA	$5.00
Annual Maximum	$5,000

Long Term Care Insurance

Unum

Unum insures the voluntary long term care (LTC) coverage for General County employees. There was a rate hold for the 2020 plan year.

3

Employee Contributions

General County – If Agreement Is Reached

For FOPPO, AFSCME and Employee's Association represented employees, the County will pay 95% of the renewal composite medical/ prescription/vision rate up to a collectively bargained capped composite amount.

The County will pay 95% of the tiered premium rates for nonrepresented employees.

	Employee Only	Employee w/ Spouse/Partner	Employee w/ Child(ren)	Employee w/ Family
NONREPRESENTED				
Providence Personal Option – Base				
Employer	$708.70	$1,417.40	$1,277.74	$2,128.94
Employee	37.30	74.60	67.26	112.06
Providence Open Option – Buy-Up				
Employer	$781.84	1,562.74	1,408.84	2,345.54
Employee	41.16	82.26	74.16	123.46
Kaiser – Value				
Employer	$658.52	1,317.06	1,185.36	1,975.58
Employee	34.66	69.32	62.38	103.98
Medical Opt Out				
Cash Back	83.00	164.00	148.00	247.00
REPRESENTED				
Providence Personal Option – Base				
Employer	666.30	1,412.30	1,265.30	2,161.30
Employee	79.70	79.70	79.70	79.70
Providence Open Option – Buy-Up				
Employer	608.10	1,430.10	1,268.10	2,254.10
Employee	214.90	214.90	214.90	214.90
Kaiser – Value				
Employer	619.84	1,313.04	1,174.40	2,006.22
Employee	73.34	73.34	73.34	73.34
Medical Opt Out				
Cash Back	185.00	185.00	185.00	185.00

General County - Dental

The County pays 100% of the premium for the Delta Dental of Oregon Incentive and Preventive dental plans and the Kaiser dental plan. The Delta Dental of Oregon Constant (50%) plan and Dental Opt Out cash back for all employees are as follows:

	Employee Only	Employee w/ Spouse/Partner	Employee w/ Child(ren)	Employee w/ Family
Delta Dental Of Oregon Constant (50%)				
Nonrepresented				
Cash Back	$48.00	$94.00	$65.00	$113.00
Represented				
Cash Back	87.00	87.00	87.00	87.00
Dental Opt Out				
Nonrepresented				
Cash Back	49.00	95.00	66.00	114.00
Represented				
Cash Back	88.00	88.00	88.00	88.00

0119 to 0120 ASO Contract Comparison (non-grandfathered)

Option Advantage, Personal Option, HSA Qualified, Choice (Medical Home)

- INITIAL 07.01.19 -

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group plans, as filed with the State of Oregon DFR for plan year 2020. 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, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0119 documents)	New Language & Provisions (in new 0120 documents)	Benefit change?	Required by reg?	Comments	Client Accepts Change? (Y/N)
ASO Handbook Changes (for all Plan types, except as otherwise denoted)								
Key Features of your Plan	All handbooks	Add new services to reflect services only covered by In-Network Providers	**1.1 KEY FEATURES OF YOUR PLAN** ***** ➢ Some Services are covered only under your In-Network benefits: • Virtual Visits, as specified in section 4.3.2; • E-mail Visit Services, as specified in section 4.3.3; • Temporomandibular Joint (TMJ) Services, as specified in section 4.12.7; • Tobacco Use Cessation Services, as specified in section 4.1.8; • Human Organ/Tissue Transplant Services, as specified in section 4.13; and • Any item listed in your Benefit Summary as "Not Covered" Out-of-Network.	**1.1 KEY FEATURES OF YOUR PLAN** ***** ➢ Some Services are covered only under your In-Network benefits: • Virtual Visits, as specified in section 4.3.2; • E-mail Visit Services, as specified in section 4.3.3; • Temporomandibular Joint (TMJ) Services, as specified in section 4.12.7; • Tobacco Use Cessation Services, as specified in section 4.1.8; • Water births, as specified in section 4.8; • Human Organ/Tissue Transplant Services, as specified in section 4.13; and • Any item listed in your Benefit Summary as "Not Covered" Out-of-Network.	Yes	No	Additional bullet point added to clarify coverage for water births and indicate benefit coverage only if done by licensed In-Network Providers. **Note:** Acceptance of Water Birth in-network limitation is *optional* for ASO. However, PHP recommends adoption to align with PHP medical policy and approach on administration of this benefit. *[AM Note: The existing language as outlined refers to the OP plan only. The Personal Option plans, by design, do not have an out of network benefit. The question is does Clackamas County want to add water births.* *The claims impact in negligible]*	**Accept?** X **Decline?** _____
Prior Authorization	All handbooks	Add new services to Prior Authorization List to reflect changes in PHP medical policy	**3.5 PRIOR AUTHORIZATION** ***** • All outpatient surgical procedures; ***** • All inpatient, residential and day, intensive outpatient, or partial hospitalization treatment Services for Mental Health and Chemical Dependency as provided in sections 4.10.1 and 4.10.3; • All Applied Behavior Analysis as provided in section 4.10.2; • All Human Organ/Tissue Transplant Services as provided in 4.13;	**3.5 PRIOR AUTHORIZATION** ***** • All outpatient surgical procedures; • Anesthesia Care with Diagnostic Endoscopy; • Gastrointestinal Endoscopy procedure; ***** • All inpatient, residential ~~and,~~ day, intensive outpatient, or partial hospitalization treatment Services for Mental Health and Chemical Dependency as provided in sections 4.10.1 and 4.10.3; • All Applied Behavior Analysis as provided in section 4.10.2; • All Human Organ/Tissue Transplant Services as provided in section 4.13;	Yes	No	Anesthesia Care with Diagnostic Endoscopy and Gastrointestinal Endoscopy procedure are added to PHP's Prior Authorization List to reflect a change in PHP medical policy and to provide greater clarity on prior authorization requirements for Members. Remainder of changes are merely minor updates to wording to provide better clarity. No impact to benefits.	
Maternity Services	All handbooks	Streamlining language used across lines of business handbooks	**4.8 MATERNITY SERVICES** ***** Women may choose to receive Maternity 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 obstetrical services), physician assistants and advanced registered nurse practitioners, certified nurse midwives, and licensed direct entry midwives. ******	**4.8 MATERNITY SERVICES** ***** Women may choose to receive Maternity 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 obstetrical services), physician assistants and advanced registered nurse practitioners specializing in women's health care, certified nurse midwives, and licensed direct entry midwives.	No	No	Additional language added to clarify coverage for water births and indicate benefit coverage only if done by licensed In-Network Providers. **Note:** Acceptance of water birth in-network limitation is *optional* for ASO. However, PHP recommends adoption to align with PHP medical policy and approach on administration of this benefit. *[Aligns with option above.*	**Accept?** X **Decline?** _____

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		Language added to provide clarification on water birth service access	**The services of a lay, unlicensed direct entry, certified professional or any other unlicensed midwife are not covered.** *****	****** **The services of a lay, unlicensed direct entry, certified professional or any other unlicensed midwife are not covered.** **Water births, regardless of location, will only be covered when performed by a licensed In-Network Provider. No coverage will be provided for water births performed by Out-of-Network Providers.** *****			*Claims impact in negligible]*	
Reconstructive Surgery	All handbooks	Language revised to comply with OAR 836-053-0012	**4.12.4 Reconstructive Surgery** Reconstructive Surgery is covered for conditions resulting from trauma, infection or other diseases and for congenital deformities and anomalies if there is a resultant functional impairment. Benefits are covered as those Services listed in the Benefit Summary based upon the type of Services received. For Restoration of Head or Facial Structures; Limited Dental Services, see section 4.12.6.	**4.12.4 Reconstructive Surgery** Reconstructive Surgery is covered for conditions resulting from congenital defects, developmental abnormalities, trauma, infection, tumors or ~~other diseases and for congenital deformities and anomalies if there is~~ disease. Reconstructive surgery may be performed to correct a ~~resultant~~ functional impairment in which the special, normal or proper action of any body part or organ is damaged; when necessary because of accidental injury or to correct scars or defects from accidental injury; or when necessary to correct scars or defects to the head or neck resulting from covered surgery. Benefits are covered as those Services listed in the Benefit Summary based upon the type of Services received. For Restoration of Head or Facial Structures; Limited Dental Services, see section 4.12.6.	No	Yes - OR state regulation; no federal mandate	Additional language added to align with PHP policy and to comply with state regulations. This is not a federal mandated change or a federal definition. This change is based on requirements of Oregon DFR, but PHP strongly encourages adoption for clarity to members and alignment with PHP medical policy. **Note:** *Optional* for ASO. *[No claims impact]*	**Accept?** _X___ **Decline?** _____
Restoration of Head/Facial Structures; Limited Dental Services	All handbooks	Language revised to align with applicable laws and current medical policy: Treatment of Craniofacial Anomaly (ORS 743A.150) and Maxillofacial Prosthetic Services (ORS 743A.148)	**4.12.6 Restoration of Head/Facial Structures; Limited Dental Services** Covered Services are limited to those Services that are Medically Necessary for the purpose of controlling or eliminating pain, or restoring facial configuration or functions such as speech, swallowing or chewing. Medically Necessary Covered Services include restoration and management of head and facial structures, including teeth, dental implants and bridges, that cannot be replaced with living tissue and that are defective because of trauma, disease or birth or developmental deformities, not including malocclusion of the jaw. ***** • The making or repairing of dentures; • Orthognathic surgery to shorten or lengthen the upper or lower jaw, unless related to a traumatic injury or to a neoplastic or degenerative disease; and	**4.12.6 Restoration of Head/Facial Structures; Limited Dental Services** Covered Services are limited to those Services that are Medically Necessary for the purpose of controlling or eliminating infection, controlling or eliminating pain, or restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic services to improve on the normal range of conditions. Medically Necessary Covered Services include restoration and management of head and facial structures, including teeth, dental implants and bridges, that cannot be replaced with living tissue and that are defective because of trauma, disease or birth or developmental deformities, not including overbite, crossbite, malocclusion or similar developmental irregularities of the teeth or jaw. ***** • The making or repairing of dentures; • Orthognathic surgery to ~~shorten~~treat developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or ~~lengthen~~similar developmental irregularities of the ~~upper or lower jaw, unless related to a~~	No	Yes - OR state regulation; no federal mandate	Additional language added to align with PHP policy and to comply with state regulations. This is not a federal mandated change or a federal definition. This change is based on requirements of Oregon DFR, but PHP strongly encourages adoption for clarity to members and alignment with PHP medical policy. **Note:** *Optional* for ASO. *[Aligns with option above.* *No claims impact]*	**Accept?** _X___ **Decline?** _____

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			• Services to treat temporomandibular joint syndrome, except as provided in section 4.12.7. ***** 	~~traumatic injury or to a neoplastic or degenerative disease~~teeth; and • Services to treat temporomandibular joint syndrome, including orthognathic surgery, except as provided in section 4.12.7. *****				
Hearing Loss Services	All handbooks	Add frequency requirements in accordance with HB 4104. Language added to cochlear implants to call out pre-existing benefits.	**4.12.11 Hearing Loss Services** ***** **Cochlear Implants:** Cochlear Implants for one or both ears, including programming and reprogramming expenses. Cochlear Implants require Prior Authorization. The devices are covered under the Surgery and applicable Facility benefit. **Hearing aids & related accessories:** Medically Necessary external hearing aids and devices, as prescribed, fitted, and dispensed by a licensed audiologist or a hearing aid/instrument specialist. Hearing aids and devices are covered under the Medical Appliances benefit. **Diagnostic & Treatment Services:** Necessary diagnostic and treatment services, including office visits for hearing tests appropriate for Member's age or development need, hearing aid checks, and aided testing. Services are covered under the applicable benefit level for the service received. For example, office visits with an audiologist are covered under the Specialist office visit benefit.	**4.12.11 Hearing Loss Services** ***** **Cochlear Implants:** Cochlear Implants for one or both ears, including programming ~~and,~~ reprogramming, replacement and repair expenses. Cochlear Implants require Prior Authorization. The devices are covered under the Surgery and applicable Facility benefit. **Hearing aids & related accessories:** Medically Necessary external hearing aids and devices, as prescribed, fitted, and dispensed by a licensed audiologist or a hearing aid/instrument specialist. Hearing aids and devices are covered under the Medical Appliances benefit. This benefit is available for one hearing aid per ear every 3 Calendar Years for all Members. **Diagnostic & Treatment Services:** Necessary diagnostic and treatment services, including office visits for hearing tests appropriate for Member's age or development need, hearing aid checks, and aided testing. Services are covered under the applicable benefit level for the service received. For example, office visits with an audiologist are covered under the Specialist office visit benefit. **Hearing Assistance Technology:** • Bone conduction sound processors, if necessary for appropriate amplification of hearing loss. This benefit is available once every 3 Calendar Years for all Members. • Hearing assistive technology systems, if necessary, for appropriate amplification of hearing loss. This benefit is available once every 3 Calendar Years for all Members.	Yes	No OR state reg only; no federal mandate	Additional language added to call out existing cochlear implant coverage pursuant to PHP medical policy. Frequency language added to hearing aids & related accessories and Hearing Assistance Technology (HAT) benefits as required by OR HB 4104 and, in part, by State of Oregon DFR in Bulletin 2018-08. ASO groups are not required to accept all or part of these Hearing Loss Services benefit changes in order to approve HATs coverage through DME. Acceptance of all or part of this Hearing Loss Service benefits change, including HATS coverage, is *optional for ASO.*	**Accept?** X **Decline?** _____
		Language added to call out Hearing Assistance Technology coverage and frequency limits						
		Removed language on Customer Service contact due to specific frequency limits added	**Limits to Hearing Loss Services** Coverage for hearing loss services are provided in accordance with state and federal law. Please contact Customer Service for specific coverage requirements.	**Limits to Hearing Loss Services** Coverage for hearing loss services are provided in accordance with state and federal law. ~~Please contact Customer Service for specific coverage requirements.~~			Customer Service language was removed due to frequency and limits being added and called out in the hearing aids & related accessories and HATs bullets.	

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							Note: These changes only apply to ASO groups with this specific pre-existing hearing coverage or groups that would like to include this state-mandated coverage in their plans. *[No claims impact]*	
Exclusions	All handbooks	Adding new standard exclusions and streamlining language used across lines of business handbooks	**5. EXCLUSIONS** ***** **General Exclusions:** **We do not cover Services and supplies which:** ***** • Are provided by or payable under any plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law; ***** • Are provided for convenience, educational or vocational purposes including, but not limited to, videos and books, educational programs to which drivers are referred by the judicial system and volunteer mutual support groups; ***** • Are payable under any automobile medical, personal injury protection~~,~~ automobile no-fault, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance makes benefits or Services available to you, whether or not you make application for such benefits or Services and whether or not you are refused payment for failure to satisfy any term of such coverage. If such coverage is required by law and you unlawfully fail to obtain it, benefits will be deemed to have been payable to the extent of that requirement. This exclusion also applies to charges applied to the Deductible of such contract or insurance. Any benefits or Services provided under this Plan that are subject to this exclusion are provided solely to assist you and such assistance does not waive our right to reimbursement or subrogation as specified in section 6.3. This exclusion also applies to Services and supplies after you have received proceeds from a settlement as specified in section 6.3.3; ***** • Relate to participation in a civil revolution or riot, duty as a Member of the armed forces of any state or country, or a war or act of war which is declared or undeclared. *****	**5. EXCLUSIONS** ***** **General Exclusions:** **We do not cover Services and supplies which:** ***** • Are provided by or payable under any health plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law; ***** • Are provided for convenience, educational or vocational purposes including, but not limited to, videos ~~and,~~ books~~,~~ and educational programs to which drivers are referred by the judicial system and volunteer mutual support groups; ***** • Are payable under any automobile medical, personal injury protection~~,~~ ("PIP"), automobile no-fault, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance makes benefits or Services available to you, whether or not you make application for such benefits or Services and whether or not you are refused payment for failure to satisfy any term of such coverage. If such coverage is required by law and you unlawfully fail to obtain it, benefits will be deemed to have been payable to the extent of that requirement. This exclusion also applies to charges applied to the Deductible of such contract or insurance. Any benefits or Services provided under this Plan that are subject to this exclusion are provided solely to assist you and such assistance does not waive our right to reimbursement or subrogation as specified in section 6.3. This exclusion also applies to Services and supplies after you have received proceeds from a settlement as specified in section 6.3.3; ***** • Relate to ~~participation in~~ a civil revolution or riot, duty as a Member of the armed forces of any state or country, or a war or act of war which is declared or undeclared. *****	No	No	See rationales explained below: *[No claims impact]*	**Accept?** X **Decline?** _____

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group plans, as filed with the State of Oregon DFR for plan year 2020. 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, as well as between different ASO plan types.

		Section reference update only applies to Personal Option handbook Additional bullet point for Viscosupplementation exclusions per existing medical policy Additional direct-to-consumer testing per existing medical policy	**We do not cover:** • Charges that are in excess of Usual, Customary and Reasonable (UCR) costs; ***** • Transportation or travel time, food, lodging accommodations and communication expenses except as provided in sections 3.6 and 4.13 and with our prior approval; ***** • Services to modify the use of tobacco and nicotine, except as provided in section 4.1.8 or when provided as Extra Values and Discounts (see our website at ProvidenceHealthPlan.com), where available; ***** • Sales taxes, handling fees and similar surcharges, as explained in the definition of UCR; and ***** • Recreation services, therapeutic foster care, emergency aid for household items and expenses; services to improve economic stability, and interpretation services; ***** • Vocational, pastoral or spiritual counseling; and • Dance, poetry, music or art therapy, except as part of an approved treatment program. ***** **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: ○ All services related to surrogate parenting, except Maternity Services as described in section 4.8; ○ All services related to in vitro fertilization, including charges for egg/semen harvesting and storage; ○ All services related to artificial insemination, including charges for semen harvesting and storage;	**We do not cover:** • Charges that are in excess of the Usual, Customary and Reasonable (UCR) ~~costs~~charges; ***** • Transportation or travel time, food, lodging accommodations and communication expenses except as provided in sections 3.8~~6~~ 8 and 4.13 and with our prior approval; ***** • Services to modify the use of tobacco and nicotine, except as provided in section 4.1.8 or when provided as Extra Values ~~and~~or Discounts (see our website at ProvidenceHealthPlan.com), where available; ***** • Sales taxes, handling fees and similar surcharges, as explained in the definition of UCR; ~~and~~ ***** • Recreation services, therapeutic foster care, wraparound Services; emergency aid for household items and expenses; services to improve economic stability, and interpretation services; ***** • Vocational, pastoral or spiritual counseling; ~~and~~ • Viscosupplementation (i.e., hyaluronic acid/hyaluronan injection); • All Direct-to-Consumer testing products; and • Dance, poetry, music or art therapy, except as part of an approved treatment program. ***** **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: ○ All services related to surrogate parenting, except Maternity Services as described in section 4.8; ○ All services related to in vitro fertilization, including charges for egg/semen harvesting and storage; ○ All services related to artificial insemination, including charges for semen harvesting and storage;			_____ Additional bullet point added to clarify Viscosupplementation and direct-to-consumer testing exclusions, per PHP medical policy. _____ Additional bullet point for clarification on fertility preservation exclusion per existing PHP medical policy.	

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		Additional bullet point for fertility preservation exclusion per pre-existing medical policy Bullet point on exclusion of condoms and birth control removed per pre-existing medical policy and ACA requirements Language added to bullet point under Hearing Services exclusion to call out services that are not provided within pre-existing coverage listed in 4.12.11. Section Reference correction **applies only to the HSA Qualified** handbook	○ Diagnostic testing and associated office visits to determine the cause of infertility; ***** • Termination of pregnancy, unless there is a severe threat to the mother, or if the life of the fetus cannot be sustained; • Reversal of voluntary sterilization; • Condoms and other over-the-counter birth control products; and • Services provided in a premenstrual syndrome clinic or holistic medicine clinic. ***** **Exclusions that apply to Hearing Services:** • Hearing aids, hearing therapies and/or devices, except as provided in section 4.12.11. **Exclusions that apply to Dental Services:** • Oral surgery (non-dental or dental) or other dental services (all procedures involving the teeth, wisdom teeth, areas surrounding the teeth, dental implants), except as approved by us and described in section 4.12.6; **Exclusions that apply to Foot Care Services:** • Routine foot care, such as removal of corns and calluses, except for Members with diabetes; and • Services for orthotics, insoles, arch supports, heel wedges, lifts and orthopedic shoes, except as provided in section 4.9.2.	○ All services and prescription drugs related to fertility preservation; ○ Diagnostic testing and associated office visits to determine the cause of infertility; ***** • Termination of pregnancy, unless there is a severe threat to the mother, or if the life of the fetus cannot be sustained; • Reversal of voluntary sterilization; and • Male condoms and other over-the-counter birth control products for men; and • Services provided in a premenstrual syndrome clinic or holistic medicine clinic. ***** **Exclusions that apply to Hearing Services:** • Hearing aids, hearing therapies and/or devices, including all services related to the examination and fitting of the hearing aids, except as provided in section 4.12.11. **Exclusions that apply to Dental Services:** • Oral surgery (non-dental or dental) or other dental services (all procedures involving the teeth, wisdom teeth, areas surrounding the teeth, and dental implants), except as approved by us and described in section 4.12.6; **Exclusions that apply to Foot Care Services:** • Routine foot care, such as removal of corns and calluses, except for Members with diabetes; and • Services for orthotics, insoles, arch supports, heel wedges, lifts and orthopedic shoes, except as ~~provided~~described in section 4.9.2.			This only applies to groups that do not have fertility preservation coverage. **Note:** *Optional* for ASO. _____ Clarification of exclusion language to denote it only applies to male contraceptive products, not female contraceptive products which are required by the ACA. Language added to bullet point under Hearing Services exclusion to clarify specific services that are not provided within existing coverage listed in 4.12.11. Note: This change only applies to ASO groups that exclude hearing aid exams. _____ Remainder of changes are merely minor language edits to streamline language across handbooks.	
General Language/Miscellaneous Changes							
Provider Directory link	All handbooks	Update all links used in reference to provider directory location on website	ProvidenceHealthPlan.com	~~ProvidenceHealthPlan.com~~http://phppd.providence.org/	No	No	Provider directory link update on Providence website. Update will be reflected in any sections that were not previously updated.	
Plan name Reference	All handbooks	Streamlining language used across lines of business handbooks	**2.1 [PLAN NAME]** ***** If you are unsure about a physician/provider's, Hospital's or other facility's participation with Providence Health Plan, visit the Provider Directory, available online at ProvidenceHealthPlan.com, before you make an appointment. You also can call Customer Service to get	**2.1 [PLAN NAME]** ***** If you are unsure about a physician/provider's, Hospital's or other facility's participation with Providence Health Plan, visit ~~the~~our Provider Directory, available online at ~~ProvidenceHealthPlan.com,~~http://phppd.providence.org/ , before you make an appointment. You can also ~~can~~ call	No	No	Minor language change to establish consistency across all PHP handbooks.	

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			information about a provider's participation with Providence Health Plan and your covered services. *****	Customer Service to get information about a provider's participation with Providence Health Plan your covered services. *****				
Member Handbook	All handbooks	Streamlining language used across lines of business handbooks	**2.2 MEMBER HANDBOOK** ***** If you need detailed information for a specific problem or situation, contact your Employer or Customer Service. *****	**2.2 MEMBER HANDBOOK** ***** If you need more detailed information for a specific problem or situation, contact your Employer or Customer Service. *****	No	No	Minor language change to establish consistency across all PHP handbooks.	
Wellness Benefits	All handbooks	Add language addressing health coaching wellness benefits	**2.7 WELLNESS BENEFITS** ***** • Health education classes ○ You can access by calling the Providence Resource Line at 800-562-8964 or visiting www.providence.org/classes. • Wellness information ***** *****	**2.7 WELLNESS BENEFITS** ***** • Health education classes ○ You can access by calling the Providence Resource Line at 800-562-8964 or visiting www.providence.org/classes. • Providence Health Coaching ○ Members can receive free coaching support for weight loss, diabetes prevention, nutrition, stress management, exercise, sleep and tobacco cessation. ○ You can access by calling 503-574-6000 (TTY: 711) or 888-819-8999 or visiting www.ProvidenceHealthPlan.com/healthcoach. • Providence Care Management ○ Members can receive information and assistance with healthcare navigation and managing chronic conditions from a Registered Nurse Care Manager. ○ You can access by calling 800-662-1121 or emailing caremanagement@providence.org. • Wellness information *****	No	No	Health coaching and Care management benefit language added to reflect existing wellness benefit services available to members. DFR requires that we explicitly disclose this per ORS 746.035. However, PHP recommends adoption of additional language to provide greater clarity on the coverage for members. Note: This change only applies to the groups that have Health Coaching benefits and/or Care Management benefits.	
Privacy of Member Information	All handbooks	Revising language to better reflect how we protect member information	**2.8 PRIVACY OF MEMBER INFORMATION** At Providence Health Plan, we respect the privacy and confidentiality of your protected health information (PHI). Providence Health Plan takes great care to determine when it is appropriate to share your PHI, in accordance with federal and state privacy laws. We use protected health information and may share it with others as part of your treatment, payment for your treatment, and our business operations.	**2.8 PRIVACY OF MEMBER INFORMATION** At Providence Health Plan, we respect the privacy and confidentiality of your protected health information. ~~Providence Health Plan takes great care to determine when it is appropriate to share your PHI, in accordance with federal and state privacy laws. We use protected health information and may share it with others as part of your treatment, payment for your treatment, and our business operations~~We are required by law to maintain	No	No	Revision to Privacy language for clarification of how member personal information is protected by PHP.	

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				the privacy of your protected health information, (commonly called PHI or your personal information) including in electronic format. When we use the term "personal information," we mean information that identifies you as an individual (such as your name and Social Security Number, as well as financial, health and other information about you that is nonpublic), which we obtain so we can provide you with the benefits and coverage under your Employer's plan. Providence Health Plan maintains policies that protect the confidentiality of personal information, including Social Security numbers, obtained from its Members in the course of its regular business functions.				
			The following are ways we may use or share information about you, consistent with law: • We will use the information to administer your benefits and help pay your medical bills that have been submitted to us for payment. • We may share your information with your doctors or Hospitals to help them provide medical care to you (e.g., if you are in the Hospital, we may give them access to any medical records sent to us by your doctor). • We may use or share your information with others to help manage your health care (e.g., we might talk to your doctor to suggest a disease management or wellness program that could help improve your health). • We may share your information with individuals who perform business functions for us. We will only share your information if there is a business need to do so and if our business partner agrees to protect the information. • We may use your information to provide you with information about alternative medical treatments and programs or about health related products and services that you may be interested in (e.g., we sometimes send out newsletters that let you know about "healthy living" alternatives such as smoking cessation or weight loss programs). We make every effort to release only the minimum amount of information necessary to meet any release requirement and only release information on a need to know basis. Also, wherever feasible, identifiable information is removed from any information shared.	~~The following are ways we may use or share information about you, consistent with law:~~ ~~• We will use the information to administer your benefits and help pay your medical bills that have been submitted to us for payment.~~ ~~• We may share your information with your doctors or Hospitals to help them provide medical care to you (e.g., if you are in the Hospital, we may give them access to any medical records sent to us by your doctor).~~ ~~• We may use or share your information with others to help manage your health care (e.g., we might talk to your doctor to suggest a disease management or wellness program that could help improve your health).~~ ~~• We may share your information with individuals who perform business functions for us. We will only share your information if there is a business need to do so and if our business partner agrees to protect the information.~~ ~~• We may use your information to provide you with information about alternative medical treatments and programs or about health related products and services that you may be interested in (e.g., we sometimes send out newsletters that let you know about "healthy living" alternatives such as smoking cessation or weight loss programs).~~ ~~We make every effort to release only the minimum amount of information necessary to meet any release requirement and only release information on a need to know basis. Also, wherever feasible, identifiable information is removed from any information shared.~~				

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			To secure the confidentiality of medical information, we have procedures in place which you can review at ProvidenceHealthPlan.com/privacy. When Member information is used in health studies, identifiable information is not released. All Member-specific information has identifying information removed, and aggregated data are used as early in the measurement process as possible. The privacy of our Members is completely protected. Our agreements with Medical Homes and In-Network Providers contain confidentiality provisions that require providers treat your personal health information with the same care. You have the right to ask us to restrict how we use or disclose your information for treatment, payment or health care operations. You also have the right to ask us to restrict information we may give to persons involved in your care. While we may honor your request for restrictions, we are not required to agree to these restrictions. You also have the right to register a complaint if you believe your privacy is compromised in any manner. Members may request to see their medical records. Call your physician's or provider's office to ask how to schedule a visit for this purpose. For more information about uses and disclosures of Member information, including uses and disclosures required by law, please refer to our Notice of Privacy Practices. A copy is available at ProvidenceHealthPlan.com/privacy or by calling Customer Service. ***** **Confidentiality and your Employer** In accordance with the federal privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), Providence Health Plan will not disclose a Member's protected health information (PHI) to the Employer or any agent of the Employer unless requested for the HIPAA allowed purpose of the Employer's obtaining bids from other health plans for further health coverage or for the Employer's modifying, amending, or terminating any benefit under the health plan. Although	~~To secure the confidentiality of medical information, we have procedures in place which you can review at ProvidenceHealthPlan.com/privacy.~~ ~~When Member information is used in health studies, identifiable information is not released. All Member-specific information has identifying information removed, and aggregated data are used as early in the measurement process as possible. The privacy of our Members is completely protected.~~ ~~Our agreements with Medical Homes and In-Network Providers contain confidentiality provisions that require providers treat your personal health information with the same care.~~ ~~You have the right to ask us to restrict how we use or disclose your information for treatment, payment or health care operations. You also have the right to ask us to restrict information we may give to persons involved in your care. While we may honor your request for restrictions, we are not required to agree to these restrictions. You also have the right to register a complaint if you believe your privacy is compromised in any manner.~~ Members may request to see or obtain their medical records~~. from their provider.~~ Call your physician's or provider's office to ask how to ~~schedule a visit for this purpose~~receive a copy. For more information about uses and disclosures of Member information, including uses and disclosures required by law, please refer to our Notice of Privacy Practices. A copy is available at ~~ProvidenceHealthPlan.com/privacy~~https://healthplans.providence.org/members/rights-notices or by calling Customer Service. ***** **Confidentiality and your Employer** In accordance with the federal privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), Providence Health Plan will not disclose a Member's protected health information (PHI) to the Employer or any agent of the Employer unless requested for the HIPAA allowed purpose of the Employer's obtaining bids from other health plans for further health coverage or for the Employer's modifying, amending, or terminating any benefit under the health plan. ~~Although~~				

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			allowable by HIPAA, Providence Health Plan's practice is to deidentify, or masks personal identifiers, on claims data released for these purposes. In all other circumstances, Providence Health Plan does not disclose a Member's PHI to an Employer or any agent of the Employer, Should Providence Health Plan change this practice, a Member's PHI would not be released to an Employer or any agent of the Employer unless Providence Health Plan determines that such disclosure is: 1. In compliance with the applicable provisions of HIPAA; and 2. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer, under which the Employer agrees to limit further disclosures to those permitted by law and plan documents, to ensure that any person or subcontractor with whom the PHI is disclosed makes similar agreements, not to use PHI for employment-related actions or decisions, not to use PHI for purposes related to any other benefits, to provide access to individuals to their PHI except as limited by law, to amend PHI as provided by law, to account for access to and disclosures of PHI as provided by law, to provide Providence Health Plan information Providence Health Plan may need to provide individuals with accountings of disclosures, to be audited by the US Department of Health & Human Services as to its handling of PHI, to return all PHI to Providence Health Plan when no longer required, to identify employees or classes of employees that need access to PHI and to prevent access to PHI for employees or classes of employees who are not identified as needing access to PHI, and to report to Providence Health Plan any violations of these principles. An Employer who receives PHI from Providence Health Plan must maintain policies and procedures that demonstrate compliance with the foregoing expectations, including procedures for the return, destruction and restriction of further use of PHI, and procedures for taking action if	~~allowable by HIPAA~~In these circumstances, Providence Health ~~Plan's practice~~Plan may release summary health information, which is ~~to deidentify, or masks personal~~PHI from which your name, ID number, dates smaller than a year, and certain other identifiers~~, on claims data released for these purposes~~ have been removed. ~~In all other circumstances,~~ Providence Health Plan ~~does not~~may disclose a Member's PHI to an Employer or any agent of the Employer~~, Should Providence Health Plan change this practice, a Member's PHI would not be released to an Employer or any agent of~~ if the ~~Employer unless Providence Health Plan determines that such~~ disclosure is: 1. In compliance with the applicable provisions of HIPAA; and ~~2. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer, under which the Employer agrees to limit further disclosures to those permitted by law and plan documents, to ensure that any person or subcontractor with whom the PHI is disclosed makes similar agreements, not to use PHI for employment-related actions or decisions, not to use PHI for purposes related to any other benefits, to provide access to individuals to their PHI except as limited by law, to amend PHI as provided by law, to account for access to and disclosures of PHI as provided by law, to provide Providence Health Plan information Providence Health Plan may need to provide individuals with accountings of disclosures, to be audited by the US Department of Health & Human Services as to its handling of PHI, to return all PHI to Providence Health Plan when no longer required, to identify employees or classes of employees that need access to PHI and to prevent access to PHI for employees or classes of employees who are not identified as needing access to PHI, and to report to Providence Health Plan any violations of these principles. An Employer who receives PHI from Providence Health Plan must maintain policies and procedures that demonstrate compliance with the foregoing expectations, including procedures for the return, destruction and restriction of further use of PHI, and procedures for taking action if~~				

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			employees or subcontractor's inappropriately use or disclose PHI. Providence Health Plan will disclose a Member's PHI with whom and in ways permitted by HIPAA. These uses are covered in detail in Providence Health Plan's Notice of Privacy Practices available online, or by mail if you request it. Providence Health Plan will only use or disclose a Member's PHI for treatment purposes, operational purposes, payment purposes, or for any reasonable purposes to which the Member has consented.	~~employees or subcontractor's inappropriately use or disclose PHI.~~ 2. Due to a HIPAA-compliant authorization, the Member has completed to allow the Employer access to the Member's PHI; or 3. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer. The details of this required certification can be reviewed at https://healthplans.providence.org/about-us/privacy-notices-policies/protected-health-information-and-your-employer/. Providence Health Plan will disclose a Member's PHI with whom and in ways permitted by HIPAA. These uses are covered in detail in Providence Health Plan's Notice of Privacy Practices available online, or by mail if you request it. ~~Providence Health Plan will only use or disclose a Member's PHI for treatment purposes, operational purposes, payment purposes, or for any reasonable purposes to which the Member has consented.~~				
In-Network Providers	All handbooks except Choice/Medical Home	Switching out description of service area to generic service area terminology	**3.1 IN-NETWORK PROVIDERS** Providence Health Plan has contractual arrangements with certain physicians/providers, hospitals and facilities located in Oregon and southwest Washington. Our agreements with these "In-Network Providers" enable you to receive quality health care for a reasonable cost. *****	**3.1 IN-NETWORK PROVIDERS** Providence Health Plan has contractual arrangements with certain physicians/providers, hospitals and facilities ~~located in Oregon and southwest Washington~~. Our agreements with these "In-Network Providers" enable you to receive quality health care for a reasonable cost.	No	No	Removal of state specific service area language to establish language consistency across all PHP handbooks.	
In-Network Providers	HSA Qualified and Option Advantage only	Switching out description of service area to generic service area terminology Streamlining language used across lines of business handbooks	**3.1 IN-NETWORK PROVIDERS** ***** **For Services to be covered using your In-Network benefit, you must receive Services from In-Network Providers. It is your responsibility to verify whether or not a physician/provider, Hospital or other facility is participating with us even if you have been directed or referred for care by an In-Network Provider.**	**3.1 IN-NETWORK PROVIDERS** ***** **For Services to be covered using your In-Network benefit, you must receive Services from In-Network Providers. It is your responsibility to verify whether or not a physician/provider, Hospital or other facility is ~~participating with us~~an In-Network Provider even if you have been directed or referred for care by an In-Network Provider.**	No	No	Minor language change to streamline language across handbooks.	
Services provided by out of network providers	All handbooks except Personal Option	Streamlining language used across lines of business handbooks	**3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS** ***** • Any item listed in your Benefit Summary as "Not Covered" Out-of-Network. *****	**3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS** ***** • Any item listed in your Benefit Summary as "Not Covered" under Out-of-Network. *****	No	No	Minor language change to streamline language across handbooks.	

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Prior Authorization	All handbooks	Streamlining language used across lines of business handbooks	**3.5 PRIOR AUTHORIZATION** While Prior Authorization is a requirement for coverage of certain Services under this Plan, Prior Authorization is not a treatment directive. The actual course of medical treatment that a Member chooses remains strictly a matter between the Member and the provider and is separate from the Prior Authorization requirements of this Plan. Prior Authorization is not a guarantee of benefit payment under this Plan and Prior Authorization does not supersede other specific provisions of this Plan regarding coverage, limitations, exclusions and Medical Necessity. *****	**3.5 PRIOR AUTHORIZATION** While Prior Authorization is a requirement for coverage of certain Services under this Plan, Prior Authorization is not a treatment directive. The actual course of medical treatment that a Member chooses remains strictly a matter between the Member and the provider and is separate from the Prior Authorization requirements of this Plan. Prior Authorization is not a guarantee of benefit payment under this Plan and a Prior Authorization determination does not supersede other specific provisions of this Plan regarding coverage, limitations, exclusions and Medical Necessity. *****	No	No	Minor language change to streamline language across handbooks.	
Understanding Out-of-Pocket Maximums	All handbooks except Personal Option	Correcting section title	**3.11.2 Understanding Out-of-Pocket Maximums** ***** ***Separate In-Network and Out-of-Network Maximums:*** Your Plan has Separate In-Network and Out-of-Network Out-of-Pocket Maximums, as listed in your Benefit Summary. Your In-Network Out-of-Pocket Maximum can be met by payments you make for Covered Services received using your In-Network benefit, and your Out-of-Network Out-of-Pocket Maximum can be met by payments you make for Covered Services received using your Out-of-Network benefit. **These In-Network and Out-of-Network Out-of-Pocket Maximums accumulate separately and are not combined.** *****	**3.11.2 Understanding Out-of-Pocket Maximums** ***** ***Separate In-Network and Out-of-Network Out-of-Pocket Maximums:*** Your Plan has Separate In-Network and Out-of-Network Out-of-Pocket Maximums, as listed in your Benefit Summary. Your In-Network Out-of-Pocket Maximum can be met by payments you make for Covered Services received using your In-Network benefit, and your Out-of-Network Out-of-Pocket Maximum can be met by payments you make for Covered Services received using your Out-of-Network benefit. **These In-Network and Out-of-Network Out-of-Pocket Maximums accumulate separately and are not combined.** *****	No	No	Minor language change to correct title to section. This change only applies to ASO groups who have separate OOP maximum language in their handbooks.	
Prostate Cancer Screening Exams	All handbooks	Streamlining language used across lines of business handbooks	**4.1.3 Prostate Cancer Screening Exams** ***** Benefits for prostate cancer screening examinations include a digital rectal examination and a prostate-specific antigen test, biennially for men 50 and older, or as recommended by a Qualified Practitioner for men designated high risk.	**4.1.3 Prostate Cancer Screening Exams** ***** Benefits for prostate cancer screening examinations include a digital rectal examination and a prostate-specific antigen test, biennially for men 50 and older, or as recommended by ~~a~~your Qualified Practitioner for men designated as high risk.	No	No	Minor language change to streamline language across handbooks.	
Colorectal Cancer Screening Exams	All handbooks	Streamlining language used across lines of business handbooks	**4.1.4 Colorectal Cancer Screening Exams** ***** Benefits for colorectal cancer screening examinations for Members age 50 and older include: • One fecal occult blood test per year, plus one sigmoidoscopy every five years; • One colonoscopy every 10 years; or • One double contrast barium enema every five years. Screening examinations and lab tests for Members designated high-risk are covered as recommended by the Qualified Practitioner. *****	**4.1.4 Colorectal Cancer Screening Exams** ***** Benefits for colorectal cancer screening examinations for Members age 50 and older include: • One fecal occult blood test per year, plus one sigmoidoscopy every five years; • One colonoscopy every 10 years; or • One double contrast barium enema every five years. Screening examinations and lab tests for Members designated as high-risk are covered as recommended by ~~the~~ your Qualified Practitioner. *****	No	No	Minor language change to streamline language across handbooks.	
Preventive Services for	All handbooks	Streamlining language used	**4.1.5 Preventive Services for Members with Diabetes**	**4.1.5 Preventive Services for Members with Diabetes**	No	No	Minor language change to streamline language across handbooks.	

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Members with Diabetes		across lines of business handbooks	Preventive Services benefits for Members diagnosed with either insulin dependent or non-insulin dependent diabetes mellitus include: • A dilated retinal exam by a qualified eye care specialist every Calendar Year; • A glycosylated hemoglobin (HbA1c) test; urine test to test kidney function; blood test for lipid levels as appropriate; visual exam of mouth and teeth (dental visits are not covered); foot inspection; and influenza vaccine by a Qualified Practitioner every Calendar Year; and A pneumococcal vaccine every five years.	Preventive Covered Services ~~benefits~~ for Members diagnosed with either insulin dependent or non-insulin dependent diabetes mellitus include: • A dilated retinal exam by a qualified eye care specialist every Calendar Year; • A glycosylated hemoglobin (HbA1c) test~~;~~, a urine test to test kidney function~~;~~, blood test for lipid levels as appropriate~~;~~, a visual exam of mouth and teeth (dental visits are not covered~~);~~), foot inspection~~;~~, and influenza vaccine by a Qualified Practitioner every Calendar Year; and A pneumococcal vaccine every five years.				
Allergy Shots, Allergy Serums and Injectable Medications	All handbooks	Modify injectable and infusion drug language for clarity	**4.3.5 Allergy Shots, Allergy Serums and Injectable Medications** Allergy shots, allergy serum, injectable medications, and total parenteral nutrition (TPN) received in your Provider's office are covered as shown in your Benefit Summary. Therapy and testing for treatment of allergies including, but not limited to, Services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment are covered only when such therapy or testing is approved by the American Academy of Allergy and Immunology, or the Department of Health and Human Services or any of its offices or agencies. Some injectable medications may require Prior Authorization, as listed in the Medical benefit drug prior authorization list available on our website at https://healthplans.providence.org/members/pharmacy-resources/Pages/default.aspx or by calling Customer Service. See section 4.7.1 for coverage of infusion at Outpatient Facilities.	**4.3.5 Allergy Shots, Allergy Serums ~~and,~~ Injectable and Infused Medications** Allergy shots, allergy serum, injectable medications, and total parenteral nutrition (TPN) received in your Provider's office are covered as shown in your Benefit Summary. Therapy and testing for treatment of allergies including, but not limited to, Services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment are covered only when such therapy or testing is approved by the American Academy of Allergy and Immunology, or the Department of Health and Human Services or any of its offices or agencies. Some injectable medications may require Prior Authorization, as listed in the Medical benefit drug prior authorization list available on our website at https://healthplans.providence.org/members/pharmacy-resources/Pages/default.aspx or by calling Customer Service. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. See section 4.7.1 for coverage of infusion at Outpatient Facilities.	No	No	Additional language added to provide members clarification on injectable and infused medication coverage and to align with PHP pharmacy policy.	
Emergency Care	All handbooks	Streamlining language used across lines of business handbooks Medical Home language only applies to the Choice handbook.	**4.5.1 Emergency Care** ***** If you or a Family Member believes that immediate assistance is needed for an Emergency Medical Condition, **call 911 or go to the nearest emergency room**. Tell the emergency personnel the name of your Medical Home Primary Care Provider and show them your Member ID Card. Call your Medical Home Primary Care Provider any time, any day of the week. Your Medical Home Primary Care Provider or the provider-on-call will tell you what to do and where to go for the most appropriate care. *****	**4.5.1 Emergency Care** ***** If you or a Family Member believes that immediate assistance is needed for an Emergency Medical Condition, **call 911 or go to the nearest emergency room**. Tell the emergency personnel the name of your ~~Medical Home~~ Primary Care Provider and show them your Member ID Card. Call your ~~Medical Home~~ Primary Care Provider any time, any day of the week. Your ~~Medical Home~~ Primary Care Provider or the provider-on-call will tell you what to do and where to go for the most appropriate care. *****	No	No	Minor language change to streamline language across handbooks. Additional language added to clarify costs are covered in full for non-emergency transportation to an In-Network facility in repatriation cases.	

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			When you are admitted to an Out-of-Network Hospital from the emergency room, your Inpatient Services are covered under your In-Network benefit until your condition becomes stable. Once your condition is stabilized, Providence Health Plan will work with you to arrange transfer to an In-Network facility. This process is called "repatriation." *****	When you are admitted to an Out-of-Network Hospital from the emergency room, your Inpatient Services are covered under your In-Network benefit until your condition becomes stable. Once your condition is stabilized, Providence Health Plan will work with you to arrange transfer to an In-Network facility. This process is called "repatriation." Costs for non-emergency medical transport to facilitate repatriation to an In-Network facility are covered in full. *****				
Urgent Care	All handbooks	Streamlining language used across lines of business handbooks Medical Home language only applies to the Choice handbook.	**4.5.5 Urgent Care** ***** Whenever you need Urgent Care, call your Medical Home Primary Care Provider first. Your Medical Home Primary Care Provider or the provider-on-call is always available, day or night. He or she may either suggest that you come to the office or go to an emergency room or urgent care center. If you can be treated in your provider's office or at an In-Network urgent care center your out-of-pocket expense will usually be lower. ***** When you are admitted to an Out-of-Network Hospital from the emergency room, your Inpatient Services are covered under your In-Network benefit until your condition becomes stable. Once your condition is stabilized, Providence Health Plan will work with you to arrange transfer to an In-Network facility. This process is called "repatriation." *****	**4.5.5 Urgent Care** ***** Whenever you need Urgent Care, call your ~~Medical Home~~ Primary Care Provider first. Your ~~Medical Home~~ Primary Care Provider or the provider-on-call is always available, day or night. He or she may either suggest that you come to the office or go to an emergency room or urgent care center. If you can be treated in your provider's office or at an In-Network urgent care center your out-of-pocket expense will usually be lower. ***** When you are admitted to an Out-of-Network Hospital from ~~the emergency room~~an urgent care facility, your Inpatient Services are covered under your In-Network benefit until your condition becomes stable. Once your condition is stabilized, Providence Health Plan will work with you to arrange transfer to an In-Network facility. This process is called "repatriation." Costs for non-emergency medical transport to facilitate repatriation to an In-Network facility are covered in full. *****	No	No	Minor language change to streamline language across handbooks. Additional language added to clarify costs are covered in full for non-emergency transportation to an In-Network facility in repatriation cases.	
Inpatient Hospital Services	All handbooks	Additional language to clarify the examples	**4.6.1 Inpatient Hospital Services** ***** Only Medically Necessary hospital Services are covered. Covered inpatient Services received in a Hospital are: • Acute (inpatient) care; • A semi-private room (unless a private room is Medically Necessary); • Coronary care and intensive care; • Isolation care; and • Hospital Services and supplies necessary for treatment and furnished by the Hospital, such as operating and recovery rooms, anesthesia, dressings, medications, whole blood and blood products, oxygen, X-ray, and laboratory Services during the period of inpatient hospitalization.	**4.6.1 Inpatient Hospital Services** ***** Only Medically Necessary hospital Services are covered. Covered inpatient Services received in a Hospital are: • Acute (inpatient) care; • A semi-private room (unless a private room is Medically Necessary); • Coronary care and intensive care; • Isolation care; and • Hospital Services and supplies necessary for treatment and furnished by the Hospital, such as use of the operating and recovery rooms, anesthesia, dressings, medications, whole blood and blood products, oxygen, X-ray, and laboratory Services during the period of	No	No	Minor language change to streamline language across handbooks.	

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			(Personal items such as guest meals, slippers, etc., are not covered.) *****	inpatient hospitalization. (Personal items such as guest meals, slippers, etc., are not covered.) *****				
Inpatient Rehabilitative Care	All handbooks	Streamlining language used across lines of business handbooks	**4.6.3 Inpatient Rehabilitative Care** Benefits are provided for physical, occupational and speech therapy Covered Services as shown in the Benefit Summary for inpatient rehabilitative care to restore or improve lost function following illness or injury. If a Member is hospitalized when rehabilitative Services begin, rehabilitation benefits will begin on the day treatment becomes primarily rehabilitative. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition. Benefits are subject to the durational limits stated in the Benefit Summary. Limits do not apply to Mental Health Covered Services. See section 4.7.2 for coverage of Outpatient Rehabilitative Services.	**4.6.3 Inpatient Rehabilitative Care** Benefits are provided for physical, occupational and speech therapy Covered Services as shown in the Benefit Summary for inpatient rehabilitative care to restore or improve lost function following illness or injury. If a Member is hospitalized when rehabilitative Services begin, ~~rehabilitation~~rehabilitative benefits will begin on the day treatment becomes primarily rehabilitative. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition. Benefits are subject to the durational limits stated in the Benefit Summary. Limits do not apply to Mental Health Covered Services. See section 4.7.2 for coverage of Outpatient Rehabilitative Services.	No	No	Minor language change to streamline language across handbooks.	
Inpatient Rehabilitative Care	All handbooks	Streamlining language used across lines of business handbooks	**4.6.4 Inpatient Habilitative Care** Coverage is provided for Medically Necessary inpatient habilitative care. If a Member is hospitalized when habilitative Services begin, habilitative benefits will begin on the day treatment becomes primarily habilitative. All Services must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. Coverage is provided at the same benefit level as Inpatient Rehabilitative Care listed in your Benefit Summary. Limits do not apply to Mental Health Covered Services. See section 4.7.3 for coverage of Outpatient Habilitative Services.	**4.6.4 Inpatient Habilitative Care** Coverage is provided, as shown in the Benefit Summary, for Medically Necessary inpatient habilitative care. If a Member is hospitalized when habilitative Services begin, habilitative benefits will begin on the day treatment becomes primarily habilitative. All Services must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. Coverage is provided at the same benefit level as Inpatient Rehabilitative Care listed in your Benefit Summary. Limits do not apply to Mental Health Covered Services. See section 4.7.3 for coverage of Outpatient Habilitative Services.	No	No	Additional language added to refer Members to their benefit summary for more coverage information.	
Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy	All handbooks	Streamlining language used across lines of business handbooks Additional sentence to clarify injectable and infused medication access. Aligns with pharmacy cost saving initiatives.	**4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy** Benefits are provided as shown in the Benefit Summary and include Services at a hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, radiation oncology, and therapeutic procedures as ordered by your Qualified Practitioner. We may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, we will not Prior Authorize the Services. For additional information about Prior Authorization, see section 3.5.	**4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy** Benefits are provided as shown in the Benefit Summary and include Services at a hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, radiation oncology, and therapeutic procedures as ordered by your Qualified Practitioner. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. We may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, we will not Prior Authorize the Services. For	No	No	Additional language added to provide members clarification on injectable and infused medication coverage and to align with PHP pharmacy policy.	

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			*****	additional information about Prior Authorization, see section 3.5. *****				
Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy	All handbooks	Streamlining language used across lines of business handbooks Add language for reviewing services 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 shown in the Benefit Summary, to restore or improve lost function following illness or injury. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition and are subject to the visit benefit maximum stated in the Benefit Summary. Limits do not apply to Mental Health Covered Services. A visit is considered a treatment with one provider (e.g., if you see a physical therapist and a speech therapist the same day at the same facility, it counts as two visits as you have received treatment from two providers). Covered Services under this benefit do **NOT** include: • Chiropractic adjustments and manipulations of any spinal or bodily area; • Exercise programs; • Rolfing, polarity therapy and similar therapies; and • Rehabilitation services provided under an authorized home health care plan as specified in section 4.11. ******	**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 ~~shown~~stated in the Benefit Summary, to restore or improve lost function following illness or injury. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition and are subject to the visit benefit maximum stated in the Benefit Summary. Limits do not apply to Mental Health Covered Services. A visit is considered a treatment with one provider (e.g., if you see a physical therapist and a speech therapist the same day at the same facility, it counts as two visits as you have received treatment from two providers). All Services are subject to review for Medical Necessity. Covered Services under this benefit do **NOT** include: • Chiropractic adjustments and manipulations of any spinal or bodily area; • Exercise programs; • Rolfing, polarity therapy and similar therapies; and • Rehabilitation services provided under an authorized home health care plan as ~~specified~~stated in section 4.11. ******	No	No	Minor language change in 4.7.2 to streamline language across handbooks. Additional language added to indicate all services for Outpatient Rehabilitative Services are subject to review for Medical Necessity.	
Outpatient Habilitative Services	All handbooks	Streamlining language used across lines of business handbooks Add language for reviewing services for medical necessity	**4.7.3 Outpatient Habilitative Services** Coverage is provided for Medically Necessary outpatient habilitative Services for maintenance, learning or improving skills and function for daily living. All Services must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. Coverage is provided at the same benefit level as Outpatient Rehabilitative Services listed in your Benefit Summary. Limits do not apply to Mental Health Covered Services. See section 4.6.4 for coverage of Inpatient Habilitative Care.	**4.7.3 Outpatient Habilitative Services** Coverage is provided, as shown in the Benefit Summary, for Medically Necessary outpatient habilitative Services ~~for maintenance, learning or improving skills and function for daily living.~~ All Services are subject to review for Medical Necessity and must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. Coverage is provided at the same benefit level as Outpatient Rehabilitative Services listed in your Benefit Summary. Limits do not apply to Mental Health Covered Services.	No	No	Additional language added to reference Benefit Summary for coverage on outpatient habilitative services. Additional language added to indicate all services for Outpatient Rehabilitative Services are subject to review for Medical Necessity.	

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				See section 4.6.4 for coverage of Inpatient Habilitative Care.				
Medical Appliances	All handbooks	Language added to call out hearing assistance technology coverage for members Streamlining language used across lines of business handbooks	**4.9.2 Medical Appliances** ***** 5. Medical devices that are surgically implanted into the body to replace or aid function (including bilateral Cochlear Implants). If you receive a procedure to implant a medical device, you will be responsible for any Copayment or Coinsurance for the medical device in additional to any Copayment or Coinsurance for the procedure. 6. Other Medically Necessary appliances as ordered by your Qualified Practitioner. ***** **4.9.4 Durable Medical Equipment (DME)** Benefits are provided for DME as shown in the Benefit Summary. Covered Services include Medically Necessary equipment such as a hospital bed, non-motorized wheelchair, ventilator, and similar equipment as approved by us. *****	**4.9.2 Medical Appliances** ***** 5. Medical devices that are surgically implanted into the body to replace or aid function (including bilateral Cochlear Implants). If you receive a procedure to implant a medical device, you will be responsible for any Copayment or Coinsurance for the medical device in ~~additional~~addition to any Copayment or Coinsurance for the procedure. 6. Other Medically Necessary appliances, including hearing aids and hearing assistance technology (HAT), as ordered by your Qualified Practitioner. ***** **4.9.4 Durable Medical Equipment (DME)** Benefits are provided for DME as shown in the Benefit Summary. Covered Services may include Medically Necessary equipment such as a hospital bed, non-motorized wheelchair, ventilator, and similar equipment as approved by us. *****	No	No	Minor language change to streamline language across handbooks. Hearing assistive technology (HAT) coverage language added to include HATs appliances under Medically Necessary benefits. **Note:** Reference to HAT in edit for section 6 only applies to those who have elected HAT coverage.	
Chemical Dependency Services	All handbooks	Streamlining language used across lines of business handbooks	**4.10.3 Chemical Dependency Services** ***** Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, and day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by us or our authorizing agent. Prior Authorization is required for all inpatient, residential, and day, intensive outpatient, or partial hospitalization treatment Services, as specified in section 3.5. *****	**4.10.3 Chemical Dependency Services** ***** Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, ~~and~~ day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by us or our authorizing agent. Prior Authorization is required for all inpatient, residential, ~~and~~ day, intensive outpatient~~,~~ or partial hospitalization treatment Services, as specified in section 3.5. *****	No	No	Minor language change to streamline language across handbooks.	
Home Health and Hospice Care	All handbooks	Streamlining language used across lines of business handbooks	**4.11 HOME HEALTH AND HOSPICE CARE**	**4.11 HOME HEALTH CARE AND HOSPICE CARE**	No	No	Minor language change to streamline language across handbooks.	
Hospice Care	All handbooks	Streamlining language used across lines of business handbooks	**4.11.2 Hospice Care** ***** • Services provided by your Qualified Practitioner or a physician associated with the hospice program;	**4.11.2 Hospice Care** ***** • Services provided by your Qualified Practitioner or a physician associated with the hospice program;	No	No	Added Durable Medical equipment acronym to align language and references throughout handbooks.	

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			• Durable Medical Equipment, medical supplies and devices, including medications used primarily for the relief of pain and control of symptoms related to the terminal illness; • Home health aide Services for personal care, maintenance of a safe and healthy environment and general support to the goals of the plan of care; *****	• Durable Medical Equipment~~,~~ (DME), medical supplies and devices, including medications used primarily for the relief of pain and control of symptoms related to the terminal illness; • Home health aide Services for personal care, maintenance of a safe and healthy environment and general support to the goals of the plan of care; *****				
Genetic Testing and Counseling Services	All handbooks	Additional language added to call out exclusion of direct-to-consumer testing	**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. Genetic testing requires Prior Authorization as shown in section 3.5.	**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. Genetic testing requires Prior Authorization as shown in section 3.5. All Direct-to-Consumer genetic tests are considered investigational and are not covered.	No	No	Language added to clarify that direct consumer genetic tests are not covered under the plan per PHP medical policy.	
Inborn Errors of Metabolism	All handbooks	Streamlining language used across lines of business handbooks	**4.12.2 Inborn Errors of Metabolism** We will provide benefits for Covered Services as shown in the Benefit Summary based upon the type of Services received for diagnosing, monitoring and controlling inborn errors of metabolism, including, but not limited to: phenylketonuria (PKU); homocystinuria; citrullinemia; maple syrup disease; and pyruvate dehydrogenase deficiency; that involve amino acid, carbohydrate and fat metabolism for which medically standard methods exist, including quantification of metabolites in blood, urine or spinal fluid, or enzyme or DNA confirmation in tissues. Covered Services include clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. For coverage of medical foods, see section 4.9.1.	**4.12.2 Inborn Errors of Metabolism** We will provide benefits for Covered Services as shown in the Benefit Summary based upon the type of Services received for diagnosing, monitoring and controlling inborn errors of metabolism, including, but not limited to: phenylketonuria (PKU); homocystinuria; citrullinemia; maple syrup disease; and pyruvate dehydrogenase deficiency; that involve amino acid, carbohydrate and fat metabolism for which medically standard methods exist, including quantification of metabolites in blood, urine ~~or~~, spinal fluid~~,~~ or enzyme or DNA confirmation in tissues. Covered Services include clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. For coverage of medical foods, see section 4.9.1.	No	No	Minor language change to streamline language across handbooks.	
Temporomandibular Joint (TMJ) Services	All handbooks	Streamlining language used across lines of business handbooks	**4.12.7 Temporomandibular Joint (TMJ) Services** Benefits are provided for TMJ Services from an In-Network Provider as shown in the Benefit Summary. Covered Services include: *****	**4.12.7 Temporomandibular Joint (TMJ) Services** Benefits are provided for TMJ Services ~~from an~~using your In-Network ~~Provider~~benefits as shown in the Benefit Summary. Covered Services include: *****	No	No	Minor language change to streamline language across handbooks.	
Human Organ/Tissue Transplant Covered Services	All handbooks	Streamlining language used across lines of business handbooks	**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.	**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.	No	No	Minor language change to streamline language across handbooks.	

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			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 benefit maximum. (Note: Travel expenses are not covered for donors.) ***** **4.13.2 Benefits for Transplant Facility Services Provided to the Organ Recipient** ***** The Global Fee and the pre-transplant and post-transplant Services apply to the Member's Out-of-Pocket Maximum.	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 expenses are not covered for donors.) ***** **4.13.2 Benefits for Transplant Facility Services Provided to the Organ Recipient** ***** The Global Fee and the pre-transplant and post-transplant Services will apply to the Member's Out-of-Pocket Maximum.				
Prescription Drug Benefit	All handbooks HSA Qualified sections are 4.14.1, 4.14.2 and 4.14.3	Streamlining language used across lines of business handbooks Changing from "purchase" to "obtain" only applies to the HSA Qualified handbook	**4.14.1 Using Your Prescription Drug Benefit** ***** • All Covered Services are subject to the Copayments and/or Coinsurance listed in the Benefit Summary. ***** • You may be assessed multiple Copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied. • You may purchase up to a 90-day supply of each maintenance drug at one time using a Participating mail service or preferred retail Pharmacy. Not all drugs are covered for more than a 30-day supply, including compounded medications, drugs obtained from specialty pharmacies, and limited distribution pharmaceuticals. To obtain prescriptions by mail, your physician or provider can call in or electronically send ~~in~~ the prescription, or you can mail your prescription along with your Providence Health Plan Member ID number to one of our Participating mail-order Pharmacies. To find our Participating mail-order Pharmacies, please visit our website at ProvidenceHealthPlan.com. (Not all prescription drugs are available through our mail-order pharmacies). ***** • Diabetes supplies and inhalation extender devices may be obtained at a Participating Pharmacy. However, these items are considered medical supplies and devices and are subject to your Medical Supplies benefits, limitations and	**4.14.1 Using Your Prescription Drug Benefit** ***** • All Covered Services are subject to the Copayments and/or Coinsurance listed in ~~the~~your Benefit Summary. ***** • You may be assessed multiple Copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied. • You may purchase up to a 90-day supply of each maintenance drug at one time using a Participating mail service or preferred retail Pharmacy. Not all drugs are covered for more than a 30-day supply, including compounded medications, drugs obtained from specialty pharmacies, and limited distribution pharmaceuticals. To obtain~~purchase~~ prescriptions by mail, your physician or provider can call in or electronically send ~~in~~ the prescription, or you can mail your prescription along with your Providence Health Plan Member ID number to one of our Participating mail-order Pharmacies. To find our Participating mail-order Pharmacies, please visit our website at ProvidenceHealthPlan.com. (Not all prescription drugs are available through our mail-order pharmacies). ***** • Diabetes supplies and inhalation extender devices may be obtained at ~~a~~your Participating Pharmacy. However, these items are considered medical supplies and devices and are subject to your Medical Supplies benefits, limitations and Copayments and/or Coinsurances. See section	No	No	Minor language change to streamline language across handbooks.	

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			Copayments and/or Coinsurances. See section 4.9.1 and your Benefit Summary. Diabetes supplies do not include glucometers and insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.9.4. ***** **4.14.2 Use of Out-of-Network Pharmacies** ***** To request reimbursement, you will need to fill out and submit to us a Prescription Drug Reimbursement form. This form is available on our website or by contacting Customer Service. When you submit the completed Prescription Drug Reimbursement form, include any itemized pharmacy receipts~~,~~ along with an explanation as to why you used an Out-of-Network Pharmacy. Submission of a claim does not guarantee payment. ***** **4.14.3 Prescription Drug Formulary** ***** The Formulary can help you and your Qualified Practitioner choose effective medications that are less costly and minimize your out-of-pocket expense. There are effective generic drug choices to treat most medical conditions. Not all FDA-approved drugs are added to the formulary. Non-formulary drug requests require a formulary exception, must be FDA-approved, Medically Necessary, and require by law a prescription to dispense. See section 6.1 under Claims Involving Prior Authorization and Formulary Exception. *****	4.9.1 and your Benefit Summary. Diabetes supplies do not include glucometers and insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.9.4. ***** **4.14.2 Use of Out-of-Network Pharmacies** ***** To request reimbursement, you will need to fill out and submit to ~~us~~Providence Health Plan a Prescription Drug Reimbursement form. This form is available on our website or by contacting Customer Service. When you submit the completed Prescription Drug Reimbursement form, include any itemized pharmacy receipts~~,~~ along with an explanation as to why you used an Out-of-Network Pharmacy. Submission of a claim does not guarantee payment. ***** **4.14.3 Prescription Drug Formulary** ***** The Formulary can help you and your Qualified Practitioner choose effective medications that are less costly and minimize your out-of-pocket expenses. There are effective generic drug choices ~~to~~that treat most medical conditions. Not all FDA-approved drugs are ~~added to the formulary~~covered by Providence Health Plan. Non-formulary drug requests require a formulary exception, must be FDA-approved, Medically Necessary, and require by law a prescription to dispense. See section 6.1 under Claims Involving Prior Authorization and Formulary Exception. *****				
		The addition of "be" only applies to the HSA Qualified handbook						
Prescription Drugs	All handbooks HSA Qualified sections are 4.14.4 and 4.14.5	Language modified to provide clarity about brand-name and generic costs to the member when they do not have a cost-share.	**4.14.4 Prescription Drugs** ***** If your brand-name benefit includes a Copayment or a Coinsurance, regardless of the reason or Medical Necessity, and you request a brand-name drug, or if your provider prescribes a brand-name drug when a generic is available, you will be responsible for the difference in cost between the brand-name and generic drug, in addition to the brand-name drug Copayment or Coinsurance indicated on the Benefit Summary. Your total cost, however, will never exceed the actual cost of the drug. The difference in cost between the brand-name and generic drug will not be applied toward your Out-of-Pocket Maximum, and you will continue to be	**4.14.4 Prescription Drugs** ***** ~~If your brand-name benefit includes a Copayment or a Coinsurance, regardless of the reason or Medical Necessity, and~~ If you request a brand-name drug, or if your provider prescribes a brand-name drug when a generic is available, regardless of the reason or Medical Necessity, you will be responsible for the difference in cost between the brand-name and generic drug, in addition to the brand-name drug Copayment or Coinsurance indicated ~~in~~ on the Benefit Summary. Your total cost, however, will never exceed the actual cost of the drug. The difference in cost between the brand-name and generic drug will	No	No	Removed language and updated text to provide clarity on brand name and generic prescription medication cost difference. Updated language to add information for who determines prescription dispensing limits.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group plans, as filed with the State of Oregon DFR for plan year 2020. 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, as well as between different ASO plan types.

			responsible for the difference in cost after your Out-of-Pocket Maximum is met. ***** **4.14.5 Prescription Drug Quantity** Prescription dispensing limits, including refills, are as follows: 1. Topicals, up to 60 grams; 2. Liquids, up to eight ounces; 3. Tablets or capsules, up to 100 dosage units; 4. Multi-use or unit-of-use, up to one container or package; as prescribed, not to exceed a 30-consecutive-day supply, whichever is less; and 5. FDA approved women's prescription contraceptives: up to 3-months initial dispensing, then up to 12-months subsequent dispensing at any Participating Pharmacy; and 6. Opioids up to 7 days initial dispensing. Other dispensing limits may apply to certain medications requiring limited use, as determined by our medical policy. Prior Authorization is required for amounts exceeding any applicable medication dispensing limits.	not be applied toward your Out-of-Pocket Maximum, and you will continue to be responsible for the difference in cost after your Out-of-Pocket Maximum is met. ***** **4.14.5 Prescription Drug Quantity** Prescription dispensing limits, including refills, are as follows: 1. Topicals, up to 60 grams; 2. Liquids, up to eight ounces; 3. Tablets or capsules, up to 100 dosage units; 4. Multi-use or unit-of-use, up to one container or package; as prescribed, not to exceed a 30-consecutive-day supply, whichever is less; ~~and~~ 5. FDA approved women's prescription contraceptives: up to 3-months initial dispensing, then up to 12-months subsequent dispensing at any Participating Pharmacy; and 6. Opioids up to 7 days initial dispensing. Other dispensing limits may apply to certain medications requiring limited use, as determined by our ~~medical policy.~~Oregon Region Pharmacy and Therapeutics Committee. Prior Authorization is required for amounts exceeding any applicable medication dispensing limits.				
		Modifying language to provide information on who determines the dispensing limits for implementation accuracy and pharmacy initiatives						
Prescription Drug Quantity	All handbooks HSA Qualified sections are 4.14.6	Streamlining language used across lines of business handbooks	**4.14.6 Prescription Drug Quantity** Up to a 90-day supply of prescribed maintenance drugs (drugs are those you have been on for at least 30 days and that you anticipate continuing on in the future) purchased from a Participating mail-order or preferred retail Pharmacy will be covered subject to the following specific provisions: *****	**4.14.6 Prescription Drug Quantity** Up to a 90-day supply of prescribed maintenance drugs (drugs ~~are those~~ you have been on for at least 30 days and that you anticipate continuing on in the future) purchased from a Participating mail-order or preferred retail Pharmacy will be covered subject to the following specific provisions: *****	No	No	Minor language change to streamline language across handbooks.	
Prescription Drug Limitations	All handbooks HSA Qualified sections are 4.14.7	Additional language in number 6 indicating the need for medical necessity	**4.14.7 Prescription Drug Limitations** ***** 6. Compound prescription drugs must contain at least one ingredient that is an FDA-approved prescription drug in therapeutic amount and must be purchased at a Participating Pharmacy. Compounded drugs from bulk powders that are not a component of an FDA–approved drug are not covered. Claims are subject to clinical review	**4.14.7 Prescription Drug Limitations** ***** 6. Compound prescription drugs must contain at least one ingredient that is an FDA-approved prescription drug in a therapeutic amount, must meet our Medical Necessity criteria and must be purchased at a Participating Pharmacy. Compounded drugs from bulk powders that are not a component of an FDA–approved drug are not covered. Claims are subject to clinical review	No	No	Additional language added to provide to clarity that Prescription drug limitations needs to meet our medical necessity criteria for coverage.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group plans, as filed with the State of Oregon DFR for plan year 2020. 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, as well as between different ASO plan types.

			for Medical Necessity and are not guaranteed for payment. *****	for Medical Necessity and are not guaranteed for payment. *****				
Prescription Drug Exclusions	All handbooks HSA Qualified sections are 4.14.8	Streamlining language used across lines of business handbooks	**4.14.8 Prescription Drug Exclusions** ***** 1. Drugs or medicines delivered, injected~~,~~ or administered for you by a physician, other provider or another trained person; 2. Amphetamines and amphetamine derivatives, except when used in the treatment of narcolepsy or hyperactivity in children and adults; 3. Drugs prescribed that do not relate to the prevention or treatment of a covered illness or injury; 4. Drugs used for the treatment of fertility/infertility; 5. Fluoride, for Members over the age of 16 years old; *****	**4.14.8 Prescription Drug Exclusions** ***** 1. Drugs or medicines delivered, injected~~,~~ or administered ~~for~~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 hyperactivity in children and adults; 3. Drugs prescribed that do not relate to the prevention or treatment of a covered illness or injury; 4. Drugs used for the treatment of fertility/infertility; 5. Fluoride, for Members over ~~the age of~~ 16 years ~~old~~of age; *****	No	No	Minor language change to streamline language across handbooks. Added section number for reference for more information on prescription drug exclusions.	
Claims Payment	All handbooks	Language modified to provide clarity to members of Preservice Claims	**6.1 CLAIMS PAYMENT** ***** **Claims Involving Prior Authorization and Formulary Exception (Pre-Service Claims)** • **For services that do not involve urgent medical conditions:** Providence Health Plan will notify your provider or you of its decision within two business days after the Prior Authorization request is received. If additional information is needed to process the request, Providence Health Plan will notify the provider and the provider will have 45 days to submit the additional information. Within two days of receipt of the additional information, Providence Health Plan will complete its review and notify your provider or you of its decision. If the information is not received within 45 days, the request will be denied. • **For services that involve urgent medical conditions:** Providence Health Plan will notify your provider or you of its decision within 72 hours after the Prior Authorization request is received. If Providence Health Plan needs additional information to complete its review, it will notify the requesting provider or you within 24 hours after the request is received. The requesting provider or you will then have 48 hours to submit the additional information. Providence Health Plan will complete its review and notify the requesting provider or you of its decision by the earlier of (a) 48 hours after the	**6.1 CLAIMS PAYMENT** ***** **Claims Involving Prior Authorization and Formulary Exception (Pre-Service Claims)** • **For Prior Authorization of services that do not involve urgent medical conditions:** Providence Health Plan will notify your provider or you of its decision within two business days after the Prior Authorization request is received. If additional information is needed to process the request, Providence Health Plan will notify the provider and the provider will have 45 days to submit the additional information. Within two days of receipt of the additional information, Providence Health Plan will complete its review and notify your provider or you of its decision. If the information is not received within 45 days, the request will be denied. • **For Prior Authorization of services that involve urgent medical conditions:** Providence Health Plan will notify your provider or you of its decision within 72 hours after the Prior Authorization request is received. If Providence Health Plan needs additional information to complete its review, it will notify the requesting provider or you within 24 hours after the request is received. The requesting provider or you will then have 48 hours to submit the additional information. Providence Health Plan will complete its review and notify the requesting provider or you of its decision by the earlier of	No	No	Minor language change to streamline language across handbooks and provide clarity on preservice of claims on member facing materials.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group plans, as filed with the State of Oregon DFR for plan year 2020. 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, as well as between different ASO plan types.

			additional information is received or, (b) if no additional information is provided, 48 hours after the additional information was due. • **For services that involve formulary exceptions:** For standard requests, Providence Health Plan will notify your provider or you of its decision within 72 hours after receipt of the request. For expedited requests, Providence Health Plan will notify your provider or you of its decision within 24 hours after receipt of the request. To qualify for expedited review, the request must be based upon exigent circumstances.	(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 ~~services that involve~~ formulary exceptions:** For standard requests, Providence Health Plan will notify your provider or you of its decision within 72 hours after receipt of the request. For expedited requests, Providence Health Plan will notify your provider or you of its decision within 24 hours after receipt of the request. To qualify for expedited review, the request must be based upon exigent circumstances.				
Timely Submission of Claims	All handbooks	Streamlining language used across lines of business handbooks Correct the ORS number stated due to it being renumbered	**6.1.1 Timely Submission of Claims** We will make no payments for claims received more than 365 days after the date of Service. Exceptions ~~may~~will be made if we receive documentation that you lacked legal capacity during that period. Payment of claims submitted by the Oregon state Medicaid agency or a prepaid managed care health services organization described in ORS 414.651 (i.e., a Coordinated Care Organization) will be made in accordance with ORS 743.847, which establishes payment requirements for claims submitted by the Oregon state Medicaid agency. *****	**6.1.1 Timely Submission of Claims** We will make no payments for claims received more than 365 days after the date of Service. Exceptions ~~may~~will be made if we receive documentation that you lacked legal capacity during that period. Payment of claims submitted by the Oregon state Medicaid agency or a prepaid managed care health services organization described in ORS 414.651 (i.e., a Coordinated Care Organization) will be made in accordance with ORS 743B.~~847~~470, which establishes payment requirements for claims submitted by the Oregon state Medicaid agency. *****	No	No	Minor language change to streamline language across handbooks. Updated ORS number to follow its newly issued number.	
Coordination with Medicare =	All handbooks	Streamlining language used across lines of business handbooks	**6.2.7 Coordination with Medicare** ***** When the Employer Group's size is 20 individuals or more, Medicare will be considered the secondary payer. *****	**6.2.7 Coordination with Medicare** ***** 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. *****	No	No	Minor language change to streamline language across handbooks.	
Informal Problem Resolution	All handbooks	Streamlining language used across lines of business handbooks Changing wording from consent to	**7.1 INFORMAL PROBLEM RESOLUTION** All employees of Providence Health Plan share responsibility for assuring Member satisfaction. If you have a problem or concern about your coverage, including benefits or Services by In-Network Providers or payment for Services by Out-of-Network Providers, please ask for our help. Customer Service is available to provide information and assistance. You may call us or meet with us at the phone number and address listed on your Member ID card. If you have special needs, such as a hearing impairment, we will make efforts to accommodate your requirements. Please contact us so we may help you with whatever special needs you may have. ***** **Authorized Representative** An individual who by law or by the consent of a Member may act on behalf of the Member.	**7.1 INFORMAL PROBLEM RESOLUTION** All employees of Providence Health Plan share responsibility for assuring Member satisfaction. If you have a problem or concern about your coverage, including benefits or Services by In-Network Providers or payment for Services by Out-of-Network Providers, please ask for our help. Your Customer Service representative is available to provide information and assistance. You may call us or meet with us at the phone number and address listed on your Member ID card. If you have special needs, such as a hearing impairment, we will make efforts to accommodate your requirements. Please contact us so we may help you with whatever special needs you may have. ***** **Authorized Representative** An individual who by law or by the ~~consent~~authorization of a Member may act on behalf of the Member.	No	No	Minor language change to streamline language across handbooks.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group plans, as filed with the State of Oregon DFR for plan year 2020. 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, as well as between different ASO plan types.

		authorization to clearly reflect how an authorized representative is selected	***** **7.2.1 Your Grievance and Appeal Rights** ***** **Urgent Medical Conditions:** If you believe your health would be seriously harmed by waiting for our decision on your Grievance or Appeal of a denied Prior Authorization or Concurrent Care request, you may request an expedited review by calling Customer Service at 503-574-7500 or 800-878-4445 outside of the Portland area. If your Appeal is urgent and qualifies for external review, you may request to have both your internal and external Appeal expedited at the same time. We will let you know by phone and letter if your case qualifies for an expedited review. If it does, we will notify you of our decision within 72 hours of receiving your request. *****	***** **7.2.1 Your Grievance and Appeal Rights** ***** **Urgent Medical Conditions:** If you believe your health would be seriously harmed by waiting for our decision on your Grievance or Appeal of a denied Prior Authorization or Concurrent Care request, you may request an expedited review by calling a Customer Service representative at 503-574-7500 or 800-878-4445 outside ~~of~~ the Portland area. If your Appeal is urgent and qualifies for external review, you may request to have both your internal and external Appeal expedited at the same time. We will let you know by phone and letter if your case qualifies for an expedited review. If it does, we will notify you of our decision within 72 hours of receiving your request. *****				
Internal Grievance or Appeal	All handbooks	Streamlining language used across lines of business handbooks	**7.2.2 Internal Grievance or Appeal** You must file your internal Grievance or Appeal within 180 days of the date on our notice of the initial Adverse Benefit Determination, or that initial Determination will become final. Please advise us of any additional information that you want considered in the review process. If you are seeing an Out-of-Network Provider, you should contact that provider's office and arrange for the necessary records to be forwarded to us for the review process. Your Grievance or Appeal will be reviewed by Providence Health Plan staff not involved in the initial determination. You may present your case in writing. Once a final determination is made, you will be sent a written explanation of the decision. *****	**7.2.2 Internal Grievance or Appeal** You must file your internal Grievance or Appeal within 180 days of the date on our notice of the initial Adverse Benefit Determination, or that initial Determination will become final. Please advise us of any additional information that you want considered in the review process. If you are seeing an Out-of-Network Provider, you should contact ~~that provider's~~the provider's office and arrange for the necessary records to be forwarded to ~~us~~Providence Health Plan for the review process. Your Grievance or Appeal will be reviewed by Providence Health Plan staff not involved in the initial determination. You may present your case in writing. Once a final determination is made, you will be sent a written explanation of the decision. *****	No	No	Minor language change to streamline language across handbooks.	
Voluntary Second Level Internal Appeal	All handbooks	Removing section 7.2.3 on voluntary internal second level appeals	**7.2.3 Voluntary Second Level Internal Appeal** **If you are not satisfied with the decision of the internal Appeal and your Appeal is of an Adverse Benefit Determination that 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 a prescription drug formulary, you may request a voluntary second level internal Appeal.** If your case is eligible, it will be reviewed by Providence Health Plan's Grievance Committee. The members of the Grievance Committee are individuals not involved in the initial decision to uphold an Appeal. You must submit your written request for the voluntary second level internal Appeal within 60 days of the date on	~~**7.2.3 Voluntary Second Level Internal Appeal**~~ ~~**If you are not satisfied with the decision of the internal Appeal and your Appeal is of an Adverse Benefit Determination that 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 a prescription drug formulary, you may request a voluntary second level internal Appeal.**~~ ~~If your case is eligible, it will be reviewed by Providence Health Plan's Grievance Committee. The members of the Grievance Committee are individuals not involved in the initial decision to uphold an Appeal. You must submit your written request for the voluntary second level internal Appeal within 60 days of the date on~~	No	No	Effective 1/01/2020, PHP has made a business decision to streamline our internal appeals process by eliminating the voluntary second level of internal appeal, which is not required by federal law. We believe this will make our administration of internal appeals more efficient and better serve our Members.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group plans, as filed with the State of Oregon DFR for plan year 2020. 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, as well as between different ASO plan types.

			the internal Grievance or Appeal decision notice, or that initial decision will become final. The Grievance Committee will review all documentation presented by you and send a written explanation of its decision within 30 days of receiving your request for the voluntary second level internal Appeal.	~~the internal Grievance or Appeal decision notice, or that initial decision will become final. The Grievance Committee will review all documentation presented by you and send a written explanation of its decision within 30 days of receiving your request for the voluntary second level internal Appeal.~~				
External Review	All handbooks	Renumber section 7.2.4 and removing mention of voluntary second level internal Appeal decision due to previous section being removed Streamlining language used across lines of business handbooks	**7.2.4 External Review** If you are not satisfied with the internal Grievance or Appeal decision or the decision of the voluntary second level internal Appeal and your Appeal is of an Adverse Benefit Determination that involves (a) medical judgment (as determined by the external reviewer) or (b) rescission of coverage (whether or not the rescission has an effect on any particular benefit at that time), you may request an external review by an IRO. The IRO is an independent review organization that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct external reviews. The IRO is entirely independent of the Plan and Providence Health Plan, and performs external reviews under a contract with Providence Health Plan. For purposes of this Plan, Plan Sponsor has delegated external review duties and obligations, as described in this section 7.2.5, to Providence Health Plan. *Time Frame for Requesting External Review* Your request for external review must be made in writing to Providence Health Plan within 4 months from the date you received the internal Grievance or Appeal decision or voluntary second level internal Appeal decision, or that internal decision will become final. If you agree, Providence Health Plan may waive the requirement that you exhaust the internal review process before beginning the External Review process.	**7.2.34 External Review** If you are not satisfied with the internal Grievance or Appeal decision ~~or the decision of the voluntary second level internal Appeal and~~ your Appeal ~~is of an Adverse Benefit Determination that~~ involves (a) medical judgment (as determined by the external reviewer) or (b) rescission of coverage (whether or not the rescission has an effect on any particular benefit at that time), you may request an external review by an IRO. The IRO is an independent review organization that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct external reviews. The IRO is entirely independent of the Plan and Providence Health Plan, and performs external reviews under a contract with Providence Health Plan. For purposes of this Plan, Plan Sponsor has delegated external review duties and obligations, as described in this section 7.2.5, to Providence Health Plan. *Time Frame for Requesting External Review* Your request for external review must be made in writing to Providence Health Plan within 4 months from the date you received the internal Grievance or Appeal decision ~~or voluntary second level internal Appeal decision~~, or that internal decision will become final. If you agree, Providence Health Plan may waive the requirement that you exhaust the internal review process before beginning the External Review process.	No	No	Section reference updates to reflect removal of Voluntary Second Level Internal Appeals.	
Eligibility and Enrollment	All handbooks	Streamlining language used across lines of business handbooks	**8. ELIGIBILITY AND ENROLLMENT** This section outlines who is eligible for coverage, and how and when to enroll yourself and your Eligible Family Dependents. No benefits shall be available to anyone not enrolled on this Plan. You and your Employer must provide us with evidence of eligibility as requested.	**8. ELIGIBILITY AND ENROLLMENT** This section outlines who is eligible for coverage, and how and when to enroll yourself and your Eligible Family Dependents. No benefits shall be available to anyone not enrolled ~~on~~under this Plan. You and your Employer must provide us with evidence of eligibility as requested.	No	No	Minor language change to streamline language across handbooks.	
Cobra Premiums	All handbooks	Streamlining language used across lines of business handbooks	**10.1.7 COBRA Premiums** If you are eligible for COBRA continuation coverage, you do not have to show that you are insurable (that you do not have any serious health conditions). However, you must pay the full Premium for your continuation coverage, including the portion of the Premium your Employer was previously paying, to your Employer. After	**10.1.7 COBRA Premiums** If you are eligible for COBRA continuation coverage, you do not have to show that you are insurable (that you do not have any serious health conditions). However, you must pay the full Premium for your continuation coverage, including the portion of the Premium your Employer was previously paying, to your Employer. After	No	No	Minor language change to streamline language across handbooks.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group plans, as filed with the State of Oregon DFR for plan year 2020. 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, as well as between different ASO plan types.

			you elect COBRA, you will have 45 days from the date of election to pay the first Premium. You must pay Premium back to the point you would otherwise have lost coverage under this Plan. After that, you must pay the Premium for each month as of the first of the month, and in all events within 30 days. If you fail to pay your monthly Premium, you will be notified that your coverage is being terminated.	you elect COBRA, you will have 45 days from the date of election to pay the first Premium. You must pay the Premium back to the point you would otherwise have lost coverage under this Plan. After that, you must pay the Premium for each month as of the first of the month, and in all events within 30 days. If you fail to pay your monthly Premium, you will be notified that your coverage is being terminated.				
Chiropractic Manipulation	All handbooks	Streamlining language used across lines of business handbooks	**13.2 CHIROPRACTIC MANIPULATION** Coverage is provided for chiropractic manipulation as stated in the Benefit Summary. To be eligible for coverage, all spinal manipulation Services must be Medically Necessary and within the Qualified Practitioner's scope of license.	**13.2 CHIROPRACTIC MANIPULATION** Coverage is provided for chiropractic manipulation as stated in the Benefit Summary. To be eligible for coverage, all ~~spinal~~chiropractic manipulation Services must be Medically Necessary and within the Qualified Practitioner's scope of license.	No	No	Minor language change to streamline language across handbooks.	
Bariatric Surgery	All handbooks HSA Qualified section is 13.5	Modification to coverage of Bariatric Surgery per PHP medical policy	**13.6 BARIATRIC SURGERY SERVICES** Coverage is provided In-Network for Medically Necessary bariatric/gastric bypass surgery for the treatment of morbid obesity in adults in accordance with the medical policy and criteria established and maintained by Providence Health Plan. Prior Authorization is required for all bariatric/gastric bypass surgery Covered Services. Approved surgical procedures may include Roux-en Y gastric bypass with an alimentary limb of 150cm or less, sleeve gastrectomy, or biliopancreatic bypass with duodenal switch, when medical necessity criteria is met. Services must be received at a Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) accredited center. To locate an approved facility, visit the MBSAQIP website at https://www.facs.org/search/bariatric-surgery-centers. Not all facilities are considered In-network, facilities must be verified by utilizing the provider directory at ProvidenceHealthPlan.com/providerdirectory. All approved bariatric/gastric bypass surgery Services will be covered at the applicable benefit level, as shown in the Benefit Summary, for the type of Services received (e.g. Provider surgery Services are covered under the "surgery and anesthesia" Provider Services benefit, facility Services are covered under the "inpatient/observation care" Hospital benefit). Deductible, Copayment, and Coinsurance will apply.	**13.6 BARIATRIC SURGERY SERVICES** Coverage is provided In-Network for Medically Necessary bariatric~~/gastric bypass~~ surgery procedures for the treatment of morbid obesity in adults in accordance with the medical policy and criteria established and maintained by Providence Health Plan. Prior Authorization is required for all bariatric~~/gastric bypass~~ surgery Covered Services. Approved surgical procedures -are outlined in the medical policy and may ~~include Roux-en Y gastric bypass with an alimentary limb of 150cm or less, sleeve gastrectomy, or biliopancreatic bypass with duodenal switch,~~be covered when medical necessity criteria is met. Services must be received at a Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) accredited center~~,~~ or PHS approved facility. To locate an approved facility, visit the MBSAQIP website at https://www.facs.org/search/bariatric-surgery-centers. Not all facilities are considered In-network, facilities must be verified by utilizing the provider directory at ~~ProvidenceHealthPlan.com/providerdirectory.~~http://phppd.providence.org/. All approved bariatric~~/gastric bypass~~ surgery Services will be covered at the applicable benefit level, as shown in the Benefit Summary, for the type of Services received (e.g. Provider surgery Services are covered under the "surgery and anesthesia" Provider Services benefit, facility Services are covered under the "inpatient/observation care" Hospital benefit). Deductible, Copayment, and Coinsurance will apply.	Yes	No	Language updated to reflect changes in PHP medical policy. This only applies to ASO groups which currently have a Bariatric Surgery benefit.	
Definitions	All handbooks	Streamlining language used across lines of	**15. DEFINITIONS** ***** **Approved Clinical Trial**	**15. DEFINITIONS** ***** **Approved Clinical Trial**	No	No	Minor language change to streamline language across handbooks.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group plans, as filed with the State of Oregon DFR for plan year 2020. 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, as well as between different ASO plan types.

		business handbooks Also including minor grammatical error corrections	Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment or cancer or other disease or condition and is one of the following: ***** **Benefit Summary** Benefit Summary means the documents with that title that are part of this Plan and summarize the benefit provisions under this Plan. ***** **Copayment** Copayment means the dollar amount that you are responsible to pay to a health care provider when you receive certain Covered Services, as shown in the Benefit Summary. *****	Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment or cancer or other life-threatening disease or condition and is one of the following: ***** **Benefit Summary** Benefit Summary means the documents with that title that are part of ~~this~~your Plan and summarize the benefit provisions under ~~this~~your Plan. ***** **Copayment** Copayment means the dollar amount that you are responsible ~~to pay~~for paying to a health care provider when you receive certain Covered Services, as shown in the Benefit Summary. *****				
		Removing Dependent definition in order to reflect accuracy of coverage	**Dependent** Dependent means a person who is supported by the Subscriber, or supported by the Subscriber's Spouse or Domestic Partner. See also Eligible Family Dependent.	**~~Dependent~~** ~~Dependent means a person who is supported by the Subscriber, or supported by the Subscriber's Spouse or Domestic Partner. See also Eligible Family Dependent.~~			_____ Removal of Dependent definition to accurately reflect coverage.	
		Removing Director definition per RCGA request	**Director** Director means the director of the Oregon Division of Financial Regulation. *****	**~~Director~~** ~~Director means the director of the Oregon Division of Financial Regulation.~~ *****			_____ Removal of Director definition as it is no longer necessary to reference in the handbook.	
		Updating Experimental/Investigational definition to reflect current medical policy	**Experimental/Investigational** Experimental/Investigational means Services that are determined by us not to be Medically Necessary or accepted medical practice in the Service Area, including Services performed for research purposes. In determining whether Services are Experimental/Investigational, we will consider whether the Services are in general use in the medical community in the U.S.; whether the Services are under continued scientific testing and research; whether the Services show a demonstrable benefit for a particular illness or disease; whether they are proven to be safe and efficacious; and whether they are approved for use by appropriate governmental agencies. We determine on a case-by-case basis whether the requested Services will result in greater benefits than other generally available Services, and will not approve such a request if the Service poses a significant risk to the health and safety of the Member. We will retain documentation of the criteria used to define a Service deemed to be	**Experimental/Investigational** Experimental/Investigational means Services ~~that are determined by us not to be Medically Necessary or accepted~~for which current, prevailing, evidence-based, peer-reviewed medical ~~practice in the~~ literature does not demonstrate the safety and effectiveness of the Service ~~Area, including Services performed for research purposes.~~for treating or diagnosing the condition or illness for which its use is proposed. In determining whether Services are Experimental/Investigational~~, we will consider whether the Services are in general use in the medical community in~~ the ~~U.S.;~~Plan considers a variety of criteria, which include, but are not limited to, whether the Services are ~~under continued scientific testing and research; whether the Services~~ : • Approved by the appropriate governmental regulatory body;			_____ Updated language for Experimental/Investigational definition to reflect current PHP medical policy.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group plans, as filed with the State of Oregon DFR for plan year 2020. 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, as well as between different ASO plan types.

			Experimental/Investigational and will make this available for review upon request. *****	• Subject to review and approval of an institutional review board (IRB) or are currently offered through an approved clinical trial; • Offered through an accredited and proficient provider in the United States; • Reviewed and supported by national professional medical societies; • Address the condition, injury, or complaint of the Member and show a demonstrable benefit for a particular illness or disease; • ~~whether they are~~ Proven to be safe and efficacious; and ~~whether they are approved for use by appropriate governmental agencies. We determine on a case-by-case basis whether the requested Services will result in greater benefits than other generally available Services, and will not approve such a request if the Service poses~~ • Pose a significant risk to the health and safety of the Member. The experimental/investigational status of a Service may be determined on a case-by-case basis. We will retain documentation of the criteria used to define a Service ~~deemed to be~~as Experimental/Investigational and will make this available for review upon request. ***** **Hearing Assistance Technology** See section 4.12.11. ***** **Providence Choice Network** Providence Choice Network means the special network of Medical Homes and In-Network Providers that have agreed to ~~serve as Medical Homes~~provide Covered Services for Members of this Plan.			
		Hearing Assistance Technology definition added to accurately reflect use as a defined term Providence Choice Network definition **only applies to the Choice handbook**	**N/A** **Providence Choice Network** Providence Choice Network means the special network of In-Network Providers that have agreed to serve as Medical Homes for Members of this Plan. *****				_____ Added Hearing Assistance Technology (HAT) definition added to reflect the referenced defined term in the handbook.	
ASO Choice (Medical Home) Handbook Changes Only								
Member Handbook	Choice	Streamlining language used across lines of	**2.2 MEMBER HANDBOOK** *****	**2.2 MEMBER HANDBOOK** *****	No	No	Minor language change to streamline language across handbooks.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group plans, as filed with the State of Oregon DFR for plan year 2020. 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, as well as between different ASO plan types.

		business handbooks	• **Provider Directory** which lists Medical Home Providers, available online at ProvidenceHealthPlan.com. If you do not have Internet access, please call Customer Service or check with your Employer's human resource department to obtain a hard copy of the directory. *****	• **Provider Directory** which lists ~~Medical Home~~In-Network Providers, available online at ~~ProvidenceHealthPlan.com.~~http://phppd.providence.org/. If you do not have Internet access, please call Customer Service or check with your Employer's human resource department to obtain a hard copy of the directory. *****				
Choosing a Medical Home	Choice	Streamlining language used across lines of business handbooks	**3.1.1 Choosing or Changing a Medical Home** Upon joining this Plan, you and each of your enrolled Family Members must choose a Medical Home as soon as possible. There are more than 200 Medical Homes to choose from. You and your covered Dependents may choose the same or different Medical Homes, depending on your preferences and needs. Once you have chosen a Medical Home, 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. Mail your completed form to: Providence Health Plan Attn: Customer Service P.O. Box 4327 Portland, OR 97208-4327 • **E-mail:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com. Email your completed form to phpcustomerservice@providence.org. • **Fax:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com. Fax your completed form to 503-574-8155. ***** **Advantages of Using a Medical Home** • Your Medical Home will work with Providence Health Plan to arrange for any Medical Home Referral or Prior Authorization that may be necessary for certain Covered Services. For more information on Prior Authorization, see section 3.5. *****	**3.1.1 Choosing or Changing a Medical Home** Upon joining this Plan, you and each of your enrolled Family Members must choose a Medical Home as soon as possible. There are ~~more than 200~~many Medical Homes to choose from. You and your covered Dependents may choose the same or different Medical Homes, depending on your preferences and needs. 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. Mail your completed form to: Providence Health Plan Attn: Customer Service P.O. Box 4327 Portland, OR 97208-4327 • **E-mail:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com. ~~Email~~E-mail your completed form to ~~phpcustomerservice~~medicalhomeselectionforms@providence.org. • **Fax:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com. Fax your completed form to 503-574-~~8155~~8208. ***** **Advantages of Using a Medical Home** • Your Medical Home will work with Providence Health Plan to arrange for any Medical Home Referral or Prior Authorization requirements that may be necessary for certain Covered Services. For more information on Prior Authorization, see section 3.5. *****	No	No	Minor language change to streamline language across handbooks. Email and phone number updated due to separate e-mail and phone implementation for medical home forms.	
		Update the e-mail address and phone number used for submitting change requests						

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group plans, as filed with the State of Oregon DFR for plan year 2020. 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, as well as between different ASO plan types.

Established Patients with Primary Care Providers	Choice	Streamlining language used across lines of business handbooks	**3.2.2 Established Patients with Primary Care Providers** If you and your family already see a provider, you may want to check the provider directory to see if your provider is a Medical Home Primary Care Provider for Providence Health Plan. If your provider is participating with us as a Medical Home, let his or her office know you are now a Providence Health Plan Medical Home Member.	**3.2.2 Established Patients with Primary Care Providers** If you and your family already see a provider, you may want to check the provider directory to see if your provider is a Medical Home Primary Care Provider for Providence Health Plan. If your provider is participating with us as a Medical Home, let his or her office know you are now a Providence Health Plan ~~Medical Home~~ Member.	No	No	Minor language change to streamline language across handbooks.	
Office Visits, Inpatient and Outpatient Hospital Visits, and Home Visits	Choice	Streamlining language used across lines of business handbooks	**4.3.1 Office Visits, Inpatient and Outpatient Hospital Visits, and Home Visits** ***** **For example** – You see your Medical Home Primary Care Provider for an office visit and during your visit your provider swabs your throat for a throat culture. You would pay your office visit Copayment or Coinsurance and would also need to pay the Laboratory Services Copayment or Coinsurance for the throat culture. See your Benefit Summary for details. *****	**4.3.1 Office Visits, Inpatient and Outpatient Hospital Visits, and Home Visits** ***** **For example** – You see your ~~Medical Home~~ Primary Care Provider for an office visit and during your visit your provider swabs your throat for a throat culture. You would pay your office visit Copayment or Coinsurance and would also need to pay the Laboratory Services Copayment or Coinsurance for the throat culture. See your Benefit Summary for details. *****	No	No	Minor language change to streamline language across handbooks.	
Inpatient Hospital Services	Choice	Streamlining language used across lines of business handbooks	**4.6.1 Inpatient Hospital Services** ***** **In-Network Benefit: When your Medical Home Provider** and Providence Health Plan determine you need hospitalization, arrangements will be made for you to be admitted to an In-Network Hospital. *****	**4.6.1 Inpatient Hospital Services** ***** **In-Network Benefit: When your ~~Medical Home~~In-Network Provider** and Providence Health Plan determine you need hospitalization, arrangements will be made for you to be admitted to an In-Network Hospital. *****	No	No	Minor language change to streamline language across handbooks.	
ASO Option Advantage (Open Option) Changes Only								
Understanding Deductibles	Option Advantage [Open Option]	Remove unnecessary language	**3.11.1 Understanding Deductibles** ***** **[Out-of-Network Deductible:** Your Plan has an **Out-of-Network Deductible**, as listed in your Benefit Summary. An Out-of-Network Deductible applies only to Covered Services received using Out-of-Network benefit. You may receive Covered Services using your In-Network benefits without meeting your Out-of-Network Deductible.]	**3.11.1 Understanding Deductibles** ***** ~~**[Out-of-Network Deductible:** Your Plan has an **Out-of-Network Deductible**, as listed in your Benefit Summary. An Out-of-Network Deductible applies only to Covered Services received using Out-of-Network benefit. You may receive Covered Services using your In-Network benefits without meeting your Out-of-Network Deductible.]~~	No	No	Removed duplicative language in regards to Out-of-Network Deductible.	

KAISER PERMANENTE

2020 *Group Agreement* and *Evidence of Coverage* Summary of Changes and Clarifications for Oregon Large Employer Groups

This is a summary of changes and clarifications that we have made to your *Group Agreement*. The *Group Agreement* includes the *Evidence of Coverage* (*EOC*), "Benefit Summary," and any applicable rider and endorsement documents. This summary does not include minor changes and clarifications we are making to improve the readability and accuracy of the *Group Agreement*. These changes and clarifications do not include changes that may occur throughout the remainder of the year as a result of federal or state mandates.

Other Group-specific or product-specific plan design changes (including changes to Copayment or Coinsurance amounts) may apply, such as moving to standard benefits. Refer to the Rate Proposal and/or the Summary of Plan Changes document for information about these types of changes.

To the extent that this summary of changes and clarifications conflicts with, modifies, or supplements the information contained in your *Group Agreement*, the information contained in the *Group Agreement* shall supersede what is set forth below. Unless another date is listed, the changes in this document are effective when your Group renews in 2020. The products named below are offered and underwritten by Kaiser Foundation Health Plan of the Northwest.

Changes and clarifications that apply to Traditional, Deductible, High Deductible, Added Choice®, and PPO Plus medical plans

Changes to Senior Advantage plans are explained at the end of this summary.

Benefit changes

- The "Referrals to Participating Providers and Participating Facilities" section of the Traditional, Deductible, and High Deductible Health Plan *EOC* has been modified. Ophthalmology has been removed from the list of departments that do not require a referral for outpatient Services. A referral will now be required to schedule an appointment for ophthalmology Services.

Benefit clarifications

- The "What You Pay" section of the *EOC* has been modified to align with changes made to the "Benefit Summary" describing all Deductible accumulation types in terms of a self-only Deductible, an individual Family Member Deductible, and a Family Deductible. The edits provide clarification to Members by distinguishing the difference between self-only and an individual in a Family. Aggregate and embedded accumulation types are now discerned by the amounts listed on the "Benefit Summary" for each of the categories.
- The "What You Pay" section of the *EOC* has been modified to align with changes made to the "Benefit Summary" describing all Out-of-Pocket accumulation types in terms of a self-only Out-of-Pocket Maximum, an individual Family Member Out-of-Pocket Maximum, and a Family Out-of-Pocket Maximum to provide clarification to Members by distinguishing the difference between self-only and an individual in a Family. Aggregate and embedded accumulation types are now discerned by the amounts listed on the "Benefit Summary" for each of these categories.
- The "Emergency, Post-Stabilization and Urgent Care" in the *EOC* has been modified to reflect a change in terminology on the "Benefit Summary." Emergency Services has been changed to emergency

department visit to more accurately describe when the emergency department visit Copayment or Coinsurance applies.

- The "Emergency Services" section of the *EOC* has been modified to specify that Emergency Services may be received anywhere in the world as long as the Services would have been covered under the "Benefits" section if received by a Participating Provider or at a Participating Facility.
- The "Preventive Care Services" section of the *EOC* has been modified to clarify that Services to diagnose current or ongoing signs or symptoms are not considered preventive and may be subject to applicable cost shares.
- The "Hearing Aid Services for Dependents" section of the *EOC* has been modified to clarify coverage requirements per the amendment of ORS 743A.141 in the 2018 Oregon House Bill (HB) 4104. A new "Hearing Aid Services for Dependents Limitations" section has been added to describe the limited coverage of replacement ear molds and hearing aid batteries as stated in HB 4104. These benefits were covered in 2019, language has been added to the 2020 contract documents for Member clarity. An exclusion has also been removed from the "Hearing Aid Services for Dependents Exclusions."
- The "Limited Outpatient Prescription Drugs and Supplies" section of the *EOC* has been modified for better alignment with the "Outpatient Prescription Drug Rider" and to provide clarity regarding how to get covered drugs and supplies.
- The "Limited Outpatient Prescription Drugs and Supplies" section of the *EOC* has been modified to clarify that lancets and injection aids are covered under the "Outpatient Durable Medical Equipment (DME)" section.
- The "Outpatient Durable Medical Equipment (DME)" section of the *EOC* has been modified to reflect that lancets and injection aids are covered under the DME benefit.
- The "Reconstructive Surgery Services" section of the Traditional, Deductible and High Deductible Health Plan *EOCs* has been modified to specify that Services are covered when prescribed by a Participating Physician and are subject to Utilization Review. The word significant has been removed in this section for consistency across products. Services are covered based upon Utilization Review.
- The "Custodial Services" exclusion in the "Exclusions and Limitations" section of the *EOC* has been changed to "Custodial Care." The exclusion has also been modified to align across lines of business for Member clarity.
- The phrase "not subject to Deductible" has been removed from several rows of the "Benefit Summary" for contract integrity and continuity. Our contract convention is to specify when benefits are subject to the Deductible and to not reference the Deductible when it does not apply. The "What You Pay" section of the *EOC* notes that the "Benefit Summary" indicates which Services are subject to the Deductible.
- The "Deductible" section of the "Benefit Summary" has been modified to describe all accumulation types in terms of a self-only Deductible, an individual Family Member Deductible, and a Family Deductible. Aggregate accumulation is represented when the individual Family Member Deductible amount equals the Family Deductible amount. Embedded accumulation is represented when the self-only Deductible amount equals the individual Family Member Deductible amount.
- The "Out-of-Pocket Maximum" section of the "Benefit Summary" has been modified to describe all accumulation types in terms of a self-only Out-of-Pocket Maximum, an individual Family Member Out-of-Pocket Maximum, and a Family Out-of-Pocket Maximum. Aggregate accumulation is represented when the individual Family Member Out-of-Pocket Maximum amount equals the Family Out-of-Pocket

Maximum amount. Embedded accumulation is represented when the self-only Out-of-Pocket Maximum amount equals the individual Family Member Out-of-Pocket Maximum amount.

- The Emergency Services row of the "Benefit Summary" has been changed to emergency department visit to more accurately reflect when the emergency department visit Copayment or Coinsurance applies.
- The "Hearing Aid Services for Dependents" section of the "Benefit Summary" has been modified to clarify coverage requirements per the amendment of ORS 743A.141 in the 2018 Oregon House Bill (HB) 4104. Language has been added to clarify that hearing aids are limited to one per ear every 36 months.
- The "Palliative and comfort care" row in the "Benefit Summary" has been removed to avoid confusion. These Services are included under hospice Services without a separate cost share.
- A row for tobacco use cessation drugs has been added to the "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" to align with covered Services listed in the *EOC*.
- The "Lancets and injection aids" row in the "Benefit Summary has been moved from the "Limited Outpatient Prescription Drugs and Supplies" section to the "Outpatient Durable Medical Equipment" section for accuracy as the DME cost share applies to these items.

Administrative changes or clarifications

- The "Definitions" section of the *EOC* has been modified. The definition of Dependent Limiting Age has been modified for consistency of terminology with the "Benefit Summary."
- The defined term "Medical Directory" has been changed throughout the Traditional, Deductible, and High Deductible Health Plan *EOCs* to "Medical Facility Directory" to accurately reflect the directory name as it appears on **kp.org**. The definition has also been modified for accuracy.
- The "Definitions" section of the *EOC* has been modified. Language indicating that a Member may contact Member Services has been removed from definitions where present, as it is not a defining characteristic and to reduce redundancy.
- The definition of "Dependent Limiting Age" has been modified for clarity.
- The "Dependents" section in the "Who is Eligible" section has been updated for clarity regarding the eligibility of a person who is under the student Dependent Limiting Age. This applies to Groups that choose to cover Dependents over the age 26 if they are full-time registered students.
- The Advice Nurses section has been modified for accuracy to reflect that an Advice Nurse may be reached by contacting the Member Services number during normal business hours, as well as, evenings, weekends, and holidays rather than contacting a specific medical office. The list of Member Services numbers has been removed to ensure accuracy and consistency. It is listed on the *EOC* cover, as well as, in the "Getting Assistance" section.
- The "Your Primary Care Participating Provider" section of the Traditional, Deductible, and High Deductible Health Plan *EOC* has been modified for accuracy, to reflect that changes to a primary care Participating Provider take effect immediately.
- Language in the "Appointments for Routine Services" section has been re-ordered for accuracy and alignment across products.
- The Member Services phone number has been removed from the body of the *EOC* (except in the "Grievances, Claims, Appeals, and External Review" section) to ensure accuracy and consistency. It is listed on the *EOC* cover, as well as, in the "Getting Assistance" section.

- The "Limited Outpatient Prescription Drugs and Supplies" section of the *EOC* has been modified. Language has been added to explain that while a Member may obtain a first fill of a prescription drug at any participating pharmacy, all refills must be obtained at a pharmacy owned and operated by Kaiser Permanente (including our mail-order pharmacy), or at another participating pharmacy we designate for covered refills.
- The "Help with Your Claim and/or Appeal" section of the *EOC* has been modified. The name of the Consumer Advocacy Unit has been updated to the Consumer Advocacy Section, a fax number has been added, the email address has been revised, and the URL has been updated for accuracy.
- In the "Grievances, Claims, Appeals, and External Review" section of the *EOC*, the Member Relations fax number has changed to accommodate a new digital fax process.
- Language in the "Termination Due to Loss of Eligibility" section of the *EOC* has been revised for clarity.
- The "Nondiscrimination" section of the *EOC* has been modified to confirm that we do not discriminate based on a Member's marital status.
- The "Limited Outpatient Prescription Drugs and Supplies" section of the Traditional, Deductible, and High Deductible Health Plan "Benefit Summary" has been modified for consistency within the contract. The word "formulary" has been removed from the row for contraceptive drugs, as all prescription drugs received from a Participating Pharmacy are formulary.
- A "Grandfathered Health Plan Coverage" section has been added to the "Miscellaneous Provisions" section of the *Group Agreement*, indicating that a Group must inform Company if coverage identified as a "grandfathered health plan" in the *EOC* does not meet (or no longer meets) the requirements for grandfathered status.

Additional changes and clarifications that apply to Added Choice® medical plans only

Benefit changes

- The "Referrals to Select Providers and Select Facilities" section of *EOC* has been modified. Ophthalmology has been removed from the list of departments that do not require a referral for outpatient Services. A referral will now be required to schedule an appointment for ophthalmology Services.

Benefit clarifications

- The "Reconstructive Surgery Services" section of the *EOC* has been modified to align with other sections within the *EOC*. Language indicating that Services are covered when prescribed by a Select, PPO, or Non-Participating Provider has been moved to the beginning of the section. Additionally, language has been added to specify that Services are subject to Utilization Review. The word significant has been removed in this section for consistency across products. Services are covered based upon Utilization Review.
- The Chiropractic Services Received Without a Referral" exclusion in the "Exclusions and Limitations" section of the *EOC* has been retitled "Chiropractic Services" for alignment with other products and other exclusions within the section.
- The "Custodial Care" exclusion in the "Exclusions and Limitations" section of the *EOC* has been modified to align across lines of business and for Member clarity.

- The "Optometric Vision Therapy and Orthoptics (Eye Exercises)" exclusion in the "Exclusions and Limitations" section of the *EOC* has been modified for clarity and moved so that it appears in alphabetical order. Language has been added explaining that Services related to optometric vision therapy and orthoptics (eye exercises) are excluded.
- A "Hospitalization on Your Effective Date" section has been added to the *EOC* for alignment across products.
- A sentence has been added to the second paragraph of the "Benefit Summary" to clarify that all applicable visit limits are combined across all tiers, unless otherwise indicated in the *EOC*. Language has been removed from the left column of the "Benefit Summary" table indicating "all tiers combined."
- A row for "certain preventive medications" has been added to the "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" to align with covered Services listed in the *EOC*.
- The "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" has been modified for better alignment with the "Outpatient Prescription Drug Rider" to more accurately reflect that these drugs may be obtained from Select Pharmacies or Medimpact Pharmacies.

Administrative changes or clarifications

- The "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" has been modified for accuracy. The word "formulary" has been removed from the row for contraceptive drugs. In addition to Select Pharmacies and Facilities, this section represents limited prescription drugs and supplies received from MedImpact Pharmacies, which are not subject to the formulary.
- The defined term "Added Choice Medical Directory" has been changed throughout the *EOC* to "Medical Facilities Directory" to accurately reflect the directory name as it appears on **kp.org**. The definition has also been modified for accuracy.
- The "Your Primary Care Select Provider" section of the *EOC* has been modified for accuracy to reflect that changes to a primary care Select Provider take effect immediately.

Additional changes and clarifications that apply to PPO Plus medical plans only

Benefit clarifications

- The "Reconstructive Surgery Services" section of the *EOC* has been modified to align with other sections within the *EOC*. Language has been moved and modified to specify that Services are subject to Utilization Review by Company. The word significant has been removed in this section for consistency across products. Services are covered based upon Utilization Review.
- The "Custodial Care" exclusion in the "Exclusions and Limitations" section of the *EOC* has been modified to align across lines of business and for Member clarity.
- A sentence has been added to the "Benefit Summary" to clarify that all applicable visit limits are combined across both tiers, unless otherwise indicated in the *EOC*. Language has been removed from the left column of the "Benefit Summary" table indicating "both tiers combined."
- The "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" has been modified for better alignment with the "Outpatient Prescription Drug Rider" to more accurately reflect that these drugs may be obtained from Medimpact or Kaiser Permanente Pharmacies.

Administrative changes or clarifications

- The "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" has been modified for accuracy. The word "formulary" has been removed from the row for contraceptive drugs. In addition to Kaiser Permanente Pharmacies, this section represents limited prescription drugs and supplies received from MedImpact Pharmacies, which are not subject to the formulary.

Changes and clarifications that apply to medical benefit riders

Benefit clarifications

- The "Alternative Care Services Rider" has been modified for better clarity around coverage for specific treatment modalities. References to the *EOC* "Exclusions and Limitations" have been moved to the subsections for each modality. Additionally, the modality references in the provider definitions have been removed.
- The "Outpatient Prescription Drug Rider" has been modified. All references to the medical directory have been updated to "Medical Facility Directory" to reflect the revised definition in the *EOC*.
- The "Outpatient Prescription Drug Rider" has been modified. A "Prior Authorization Exception Process" subsection has been added to the "About Our Drug Formulary" section to align across lines of business and ensure consistency of administration.
- The rows for tobacco use cessation drugs and contraceptives have been removed from the "Outpatient Prescription Drug Rider Benefit Summary" to reduce redundancy. These items are included in the "Limited Outpatient Prescription Drugs and Supplies" section of the *EOC*.
- References to the Deductible and Prescription Drug Deductible have been removed from the "Copayments and Coinsurance for Covered Drugs and Supplies" and "Day Supply Limit" sections of the "Outpatient Prescription Drug Rider" contract integrity and administrative consistency. The "Deductible" section of the *EOC* describes how the Deductible is applied. The "Outpatient Prescription Drug Rider Benefit Summary" indicates which Services are subject to the Deductible.
- The "About Our Drug Formulary" section in the "Outpatient Prescription Drug Rider" has been modified for accuracy and Member clarity.
- The phrase "not subject to Deductible" has been removed from several rows of the "Outpatient Prescription Drug Rider Benefit Summary" for contract integrity and continuity. Our contract convention is to specify when benefits are subject to the Deductible and to not reference the Deductible when it does not apply.
- The "Pediatric Vision Hardware and Optical Services Rider Benefit Summary" (including the rider for the enhanced benefit) has been modified for clarity. The "You Pay" cells for comprehensive eye exams and low vision evaluations have been updated to show the Member cost share rather than pointing to the primary care visit cost share in the *EOC* "Benefit Summary."

Administrative changes or clarifications

- The "Covered Drugs and Supplies" section of the "Outpatient Prescription Drug Rider" has been modified. Language has been added to explain that while a Member may obtain a first fill of a prescription drug at any participating pharmacy, all refills must be obtained at a pharmacy owned and operated by Kaiser Permanente (including our mail-order pharmacy), or at another participating pharmacy we designate for covered refills.

KAISER PERMANENTE

Changes and clarifications that apply to dental plans

Benefit clarifications

- To align with current administration, language regarding diagnosis and evaluation was removed from the Oral Surgery Services, Periodontic Services, and Endodontic Services sections and added to the Oral Exam row in the benefit summary to clarify that all exams, including diagnosis and evaluation, are subject to the Preventive and Diagnostic Services cost share.
- Benefits within the *EOC* and Benefit Summary have been alphabetized when appropriate to do so.
- The "Exclusions and Limitations" section has been modified to align across lines of business, where appropriate, ensure consistency of administration, and aid in Member clarity. This synchronization did not result in any benefit changes.
- To better align with state regulations, several limitations in the "Limitations" section have been modified by changing the language from "covered" to "limited to."

Administrative changes or clarifications

- The definition of *Dental Provider Directory* has been modified for accuracy and a new definition for *Dental Facility Directory* has been added. References throughout the *EOC* have been updated with the corresponding directory name.
- In the "Definitions" section and throughout the *EOC*, the dental PPO Third Party Administrator (TPA) name has changed from Scion Dental, Inc. to SKYGEN USA, LLC, ("SKYGEN").
- The definition of "Dependent Limiting Age" in the "Definitions" section of the *EOC* has been modified for clarity.
- The "Dependents" section under "Who is Eligible" in the *EOC* has been updated to clarify the bullet regarding the eligibility of a person who is under the student Dependent Limiting Age. This section applies to Groups that choose to cover Dependents over the age 26 if they are full-time registered students.
- The "Adding New Dependents to an Existing Account" section of the *EOC* has been modified. Language has been added to clarify that an enrollment application is required to add new dependents if additional premium is required to add the dependent and that the application requirement is waived if additional premium is not required.
- A "Referrals" section has been added to all nonPPO plans for clarity and transparency.
- The "Prior Authorization" section in PPO plans has been modified to reflect that providers can now request Prior Authorization on a Member's behalf electronically. The language about requesting prior authorization by fax has also been removed, since there is no longer a fax number on the back of Members' ID cards.
- The address in the "Post-Service Claims - Services Already Received" section has been updated to reflect that nonPPO dental claim forms should be sent to our local dental claims' office in Portland, Oregon.
- The Member Services phone number has been removed throughout the *EOC* when referring Members to contact Member Services (except in the "Grievances, Claims, and Appeals" section) to ensure accuracy and consistency. It is listed on the *EOC* cover, as well as, in the "Getting Assistance" section.

- The "Help with Your Claim and/or Appeal" section has been modified. The name of the Consumer Advocacy Unit has been updated to the Consumer Advocacy Section, a fax number has been added, the email address has been revised, and the URL has been updated for accuracy.
- In the "Grievances, Claims, and Appeals" section, the Member Relations fax number has changed to accommodate a new digital fax process.
- Language in the "Termination Due to Loss of Eligibility" section has been revised for clarity.
- The language in the "Termination for Cause" section has been revised to reflect that Members may only be terminated for fraud and misrepresentation. It has also been updated for consistency.
- The "Nondiscrimination" section has been modified to confirm that we do not discriminate based on a Member's marital status.

Changes and clarifications that apply to dental benefit riders

Benefit clarifications

- The "Dental Implant Services Rider" has been modified for clarity.
    - The first bullet in the "Dental Implant Benefit" section has been moved out of alphabetical order to the end of the list since it is a secondary alternative to the other benefits listed.
    - The "Repair of a Dental Implant" limitation has been modified to include a clarifying sentence that provides for repairs when postoperative complications or failure of a Dental Implant happens through no fault of the Member.

Changes and clarifications that apply to all Senior Advantage plans

Benefit changes and clarifications

- The following changes have been made to the Medical Benefits Chart:
    - Opioid treatment program services have been added to the Chart. Covered services include FDA-approved opioid treatment medications, substance use counseling, individual and group therapy, and toxicology testing.
    - Outpatient hospital observation services are now in a separate row of the Chart. Previously, these services were addressed under the "Emergency care" and "Outpatient hospital services" rows. Language has been added to explain to members what observation services are and the conditions for coverage.
    - More detailed information about covered telehealth services has been added to the "Physician/practitioner services, including doctor's office visits" section of the Chart. This section now describes numerous services available through telehealth when clinically appropriate.
- In Chapter 3, Section 2.2 of the *EOC*, the list of services that do not require referral has changed. Members will need a PCP referral for services from obstetrics/gynecology, occupational health and social services.
- Information has been added to Chapter 3, Section 3.2 of the *EOC* to clarify the circumstances under which we cover worldwide urgent care services outside the United States.
- For Medicare Part D plans, Chapter 5, Section 5.2 of the *EOC* has been modified to explain that we will offer a temporary supply of a non-formulary drug if the member experiences a level of care change. We

will cover up to a one-month supply of the Part D drug during level of care transitions even if the drug is not on our Drug List (formulary).

- For Medicare Part D plans, Chapter 5, Section 6.2 of the *EOC* has been edited to clarify what happens when there are changes to the Drug List (formulary); if and when coverage changes for a drug the member is taking; and how the member is notified. The Senior Advantage 2020 Annual Notice of Change (*ANOC*) that is sent to Senior Advantage members provides additional detail explaining what happens if a drug the member is taking is changed or removed from the 2020 Drug List, and what a member can do, such as working with their provider to find a different drug that we cover or to ask for a formulary exception.

Administrative changes and clarifications

- The eligibility requirements list in Chapter 1, Section 2.1 of the *EOC*, has been modified to remove a restriction. We allow enrollment in our group Senior Advantage plan when a person's Medicare coverage is either primary or secondary to the group plan.
- Information about coverage decisions, appeals and complaints in Chapter 9 of the *EOC* for plans with Medicare Part D, and Chapter 7 of the *EOC* for plans without Medicare Part D, has been updated to explain when we or the IRO must respond if the request for benefits determination is for a Medicare Part B drug.

DELTA DENTAL

Clackamas County
Oregon ASO Dental Plan Changes
Renewing January 1, 2020

The following is a summary of the significant changes that will be made to the Delta Dental ASO Agreement and member handbook when your group renews in 2020. The summary is provided for your convenience and shall not be binding upon the parties. The language in the ASO Agreement and member handbook is controlling in all cases. Minor changes, including grammatical, cosmetic or formatting changes or moving sections around for ease of use are not included in this summary.

FEDERAL REGULATORY CHANGES			
Reference	**Former Benefit**	**Change/Rationale/Exceptions**	**Claims Impact***
ACA	Delta Dental will monitor for any changes to the ACA.	To be determined	TBD

STATE REGULATORY CHANGES			
Reference	**Former Benefit**	**Change/Rationale/Exceptions**	**Claims Impact***
SB 421	When a third party is responsible for an injury, the Plan may recover claims costs.	Changes to the subrogation process may affect the Plan's ability to recover claims costs.	TBD

BENEFIT CHANGES						
Accepted		**Reference**	**Former Benefit**	**New Benefit**	**Explanation**	**Claims Impact***
Yes	**No**					
☐	☒	**Benefits and Limitations** Consultation	Consultation was covered regardless of whether the related services were covered.	Consultation in conjunction with non-covered services is denied.	Align consultation with covered services.	Negligible

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BENEFIT CHANGES						
Accepted		Reference	Former Benefit	New Benefit	Explanation	Claims Impact*
Yes	No					
☐	☒	**Benefits and Limitations** Periodic or comprehensive exams	Problem focused detailed extensive oral evaluations were covered twice per year as a limited or re-evaluation exam.	Problem focused, detailed, extensive oral evaluations are covered as a periodic / comprehensive exam.	Problem focused, detailed extensive oral evaluations are a comprehensive service.	Negligible
☐	☒	**Benefits and Limitations** Space maintainer	The Plan allowed once per space. Space maintainers for primary anterior teeth or missing permanent teeth or for members are not covered.	The Plan allows once per space per quadrant as a lifetime benefit. Space maintainers for primary anterior teeth or missing permanent teeth or for members age 14 or over are not covered.	Change based on evidence based practice.	Negligible
☒	☐	**Benefits and Limitations** Interim caries arresting medicament	Not covered.	Interim caries arresting medicament application is covered twice per tooth per benefit year. -- **YES** **NO** -Restorations within 3 months of interim caries arresting medicaments are not covered. - NO	A new service for the treatment of tooth decay.	+0.07%
☐	☒	**Benefits and Limitations** Restorative services - Basic	The Plan covers post and core in addition to crown.	The Plan denies post and core in addition to a crown unless more than half of the coronal tooth structure remains.	Change based on evidence based practice.	Negligible

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BENEFIT CHANGES						
Accepted		Reference	Former Benefit	New Benefit	Explanation	Claims Impact*
Yes	No					
☐	☒	**Benefits and Limitations** Repair to crown, inlay and onlay	The Plan reviewed for necessity if the repair was made to a crown, inlay or onlay within 24 months by a different dentist.	Repair made to a crown, inlay or onlay within 24 months is denied.	Repair is included in the charge for the original care.	Negligible
☐	☒	**Benefits and Limitations** Endodontic services	Retrograde fillings were covered.	Retrograde fillings by the same dentists within a 2-year period of the initial retrograde filling is not covered.	Retreatment is included in the charge for the original care.	Negligible
☒	☐	**Benefits and Limitations** Oral surgical services	Osseous surgery was covered subject to consultant review.	Osseous surgery is limited to 2 quadrants per date of service.	Based on evidence based dentistry.	Negligible
☐	☒	**Benefits and Limitations** Oral surgical services	Bone replacement graft was covered subject to consultant review.	Bone replacement grafts are limited to once per single tooth or multiple teeth within a quadrant in any 3-year period.	Based on evidence based dentistry.	Negligible
☒	☐	**Benefits and Limitations** Oral surgical services	Post-operative care for oral and maxillofacial surgery was covered subject to consultant review within 30 days of the surgical service.	A separate charge for post-operative care done within 30 days following oral surgery is not covered.	Post-operative care within 30 days is included in the surgery charge.	-0.25%
☐	☒	**Benefits and Limitations** Prosthodontic services	Re-cement or re-bond implant/abutment supported crown or fixed partial denture was covered.	Re-cement or re-bond implant/abutment supported crown or fixed partial denture is limited to once in any 12-month period.	Additional re-cement or re-bond is likely due to underlying issues with the implant or abutment.	Negligible

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ADMINISTRATIVE CHANGES		
Reference	**Change/Rationale/Exceptions**	**Details**
Overall	Minor changes for improved readability.	This includes separating 1 sentence into 2 and replacing some words with simpler synonyms.
Benefits and Limitations Diagnostic & Preventive	Added language stating limited exam and re-evaluation are covered up to 2 exams per plan year.	Clarifying the existing frequency for these benefits.
Benefits and Limitations Diagnostic & Preventive	Added language to explain that adult prophylaxis is only allowed for age 12 and over.	Members under 12 receive child prophylaxis.
Benefits and Limitations Endodontic services	Add language that pulpotomy in conjunction with a root canal is not covered.	The pulpotomy is included in the charge for the root canal.
Benefits and Limitations Periodontal services	Added language to clarify periodontal surgical procedures by the same dentist within a 3-year period of the initial surgery is not covered.	Additional services should be included in the cost of the initial procedure.
Benefits and Limitations Surgical Stent **Exclusions** Maxillofacial prosthetics	Added language to clarify surgical stent is covered in conjunction with covered surgical procedures. All other maxillofacial prosthetics are not covered.	Delta Dental processing policy.
Benefits and Limitations Implants	Added language to describe scaling and debridement of an implant is limited to once per implant in a 2-year period.	Language added to clarify the current process.
Benefits and Limitations Other services Orthodontia	Added language to explain that orthodontia is covered when an in-person clinical exam of the patient is performed to establish the need for orthodontics.	Clarify that self-administered orthodontics are not covered.
Benefits and Limitations Other services Teledentistry	Teledentistry is not covered as a separate benefit.	Teledentistry is included in the fees for overall patient management.
Benefits and Limitations Other services Translation	Translation or sign language service is not covered as a separate benefit.	Translation or sign language service are included in the fees for overall patient management.

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ADMINISTRATIVE CHANGES		
Reference	**Change/Rationale/Exceptions**	**Details**
Exclusions Behavior management	Added language to exclude behavior management.	Additional charges for extra time or services to manage behavioral issues are not covered.
Exclusions Copy of records	Copying a patient's records is not covered.	Dental office administrative process is not covered.
Exclusions Coping	Coping, a thin covering of the coronal portion of a tooth, is not covered.	Specialized procedures are not covered.
Exclusion Tobacco counseling	Added exclusion except if members are qualified under the Health through Oral Wellness program.	Members with enhanced benefits based on a high risk of oral cancer are eligible for tobacco cessation counseling.
Exclusions Treatment of closed fractures	Added exclusion for treatment of closed fractures.	Clarification of the current administration.
Enrollment Loss of Eligibility by Dependent	Added language clarifying that dependent coverage based legal guardianship ends when the subscriber is no longer the legal guardian.	Grandchildren are eligible when the subscriber is the legal guardian. When the guardian relationship legally ends earlier than age 26, the grandchild's coverage also ends.

ASO AGREEMENT CHANGES
None

*Based on Delta Dental book of business.

Additional changes may be required at any time as a result of new federal rules or regulations; changes to existing ACA rules or regulations or State law. Delta Dental will provide written notice of any additional changes including any modification to administrative fees, and will administer such changes accordingly.

Services are provided by Oregon Dental Service doing business as Delta Dental Plan of Oregon (Delta Dental). Delta Dental is part of the Moda organization.

Signature_____ **Date** 8/27/19

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MERCER
MAKE TOMORROW, TODAY

2020 HEALTH AND WELFARE BENEFIT PLAN PRELIMINARY RENEWAL REPORT

CLACKAMAS COUNTY

SEPTEMBER 2019

PEACE OFFICERS ASSOCIATION

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MARSH & McLENNAN COMPANIES

1

Summary

The Clackamas County Peace Officers Association (POA) 2020 health and welfare benefit plans renewal decisions are outlined in this report.

The table on the following pages is a summary of renewal rates by plan for the POA plans.

PLAN	2019 BUDGET RATE	STATUS QUO 2020 RENEWAL	% INCREASE
Active / Retiree Medical*			
POA			
Kaiser HMO Option			
EE	$674.14	$707.84	5.0%
EE, SP	1,348.30	1,415.70	5.0%
EE, CH	1,213.46	1,274.12	5.0%
EE, FAM	2,022.44	2,123.54	5.0%
COMPOSITE	$1,400.68	$1,553.58	10.9%
PHP Personal Option 15/0/1000 (Includes VSP Vision)			
EE	$724.00	$771.00	6.5%
EE, SP	1,448.00	1,542.00	6.5%
EE, CH	1,305.00	1,390.00	6.5%
EE, FAM	2,174.00	2,316.00	6.5%
COMPOSITE	$1,719.00	$1,870.00	8.8%
PHP Open Option 10/0/20/2000 $50 Common Deductible (Includes VSP Vision)			
EE	$738.00	$825.00	11.8%
EE, SP	1,475.00	1,648.00	11.7%
EE, CH	1,330.00	1,486.00	11.7%
EE, FAM	2,215.00	2,474.00	11.7%
COMPOSITE	$1,816.00	$1,998.00	10.0%
Retiree / Temporary Medical			
PHP $1000 Deductible			
EE	$741.76	$730.63	-1.5%
EE, SP	1,483.62	1,461.36	-1.5%
EE, CH	1,335.16	1,315.14	-1.5%
EE, FAM	2,225.30	2,191.92	-1.5%
Kaiser $1000 Deductible - POA			
EE	$508.48	$533.90	5.0%
EE, SP	1,016.98	1,067.80	5.0%
EE, CH	915.28	961.02	5.0%
EE, FAM	1,525.52	1,601.82	5.0%
PHP Medicare Align			
POA	$331.80		-100.0%
Kaiser Medicare			
POA	$385.62	$391.10	1.4%

Vision (VSP) – Rates and Contributions combined with Medical

POA: VSP 12/24/24; $10 copay; $130 allowance			
EE	$3.90	$3.90	0.0%
EE, SP	7.82	7.82	0.0%
EE, CH	8.36	8.36	0.0%
EE, FAM	13.38	13.38	0.0%
COMPOSITE	$10.66	$10.54	-1.1%

Dental (Delta Dental of Oregon) – Rates paid 100% by Clackamas County

POA: Delta Dental Incentive			
EE	$77.00	$73.00	-5.2%
EE, SP	150.00	143.00	-4.7%
EE, CH	108.00	103.00	-4.6%
EE, FAM	183.00	174.00	-4.9%
COMPOSITE	$149.00	$147.00	-1.3%
General County/POA: Kaiser			
EE	$103.08	$104.10	1.0%
EE, SP	204.08	206.10	1.0%
EE, CH	142.24	143.66	1.0%
EE, FAM	244.26	246.68	1.0%
COMPOSITE	$188.00	$190.00	1.1%

Life and AD&D (MetLife)			
Basic Life (Rate per $1,000 benefit)			
Represented – GC & POA	$0.196	$0.136	-30.6%
Group Universal Life			
General County and POA	Age Rated	Age Rated	0.0%
Dependent Life per Employee (Rate per Family)			
$2,000 per Dependent – POA	$0.38	$0.38	0.0%
LTD (Standard)			
Fully Insured – Peace Officers			
Base Plan (Per $100 of Covered Salary)	$0.30	$0.30	0.0%
Buy-Up Plan (Per $100 of Covered Salary)	$0.34	$0.34	0.0%
Employee Assistance Program – EAP			
Cascade (Previously with Standard)			
General Fee PEPM	$2.50	$2.50	0.0%
Flexible Spending Account			
Navia			
Monthly Fee PPPM	$5.00	$5.00	0.0%

**Rates include the standard 2020 contract changes.*

PEPM = Per Employee Per Month
PMPM = Per Member Per Month
PPPM = Per Participant Per Month

2

Medical/Prescription Drug/Vision/Alternative Care Plans

Self-Funded Plans

The 2020 projection for the Open and Personal Options called for an overall 10.5% increase for the POA.

The 2020 Providence ASO fees are shown below as per employee per month (PEPM).

Providence Health Plan Administrative Fees

	PEPM
Medical Administration	$27.50
Pharmacy Administration	5.27
Alternative Care Administration	2.24
MH/CD Administration	4.94
Case and Disease Management	9.12
Network Access Fee	8.38
Health Coaching – 12 Sessions	2.06
	$59.51

Stop Loss Administrative Fees – Optum Health

The 2020 stop loss fee has not been finalized at this time. It will be finalized by no later than the end of November. The current specific attachment point is $200,000.

Mercer's underwriting projection for the 2020 renewal is included in **Exhibit A** for reference.

Peace Officers

There were no plan changes for the 2020 plan year for the POA plans.

The standard 2020 contract changes summary for grandfathered plans in **Exhibit B** apply to the POA plans.

See **Exhibit C** for the Providence 2020 POA benefit summaries.

Retirees – Peace Officers

Early (pre-age 65) retirees are eligible for the Providence Personal and Open Option active employee plans.

For those early retirees who live outside of the Providence service area, the County offers the Traditional Option plan for medical coverage. These early retiree rates and prescription drug benefits are the same as the Open Option plans for active employees.

Open Option 15/30/50/2000 $1000 Common Deductible

The County elected no plan changes for the 2020 plan year. The 2020 benefit summary is included in **Exhibit C**.

Providence Fully-Insured Medicare Align Plan (Medicare Eligible)

The 2020 premium rate for the Providence Medicare Align plan has not been received yet.

Medicare Align Plan

Medicare Align With Prescription Drug

Exhibit B contains the standard 2020 contract changes for grandfathered plans proposed by Providence.

See **Exhibit C** for the Providence 2020 early retiree benefit summaries.

Kaiser Permanente

Peace Officers

Kaiser proposed an overall 5.0% increase to the 2019 premium rates.

POA

The POA did not elect to make benefit changes to this plan.

Kaiser's underwriting worksheets for their renewal calculations are included in **Exhibit D** for reference.

Exhibit E contains the 2020 contract changes provided by Kaiser. The POA accepted the proposed 2020 benefit and administrative clarifications.

See **Exhibit F** for the Kaiser 2020 benefit summaries.

Retirees – Peace Officers

Early (pre-age 65) retirees are eligible for the active employee HMO plan. The County also offers a $1000 deductible plan for early retirees and COBRA participants. The proposed rate increase of 5.0% for the POA plan was accepted by the County.

Medicare-Eligible retirees (age 65 and over) are eligible for the Medicare Supplement plan. Premium rates increased by 1.4%.

Exhibit E contains the 2020 contract changes provided by Kaiser.

See **Exhibit F** for the Kaiser 2020 benefit summaries.

Vision Plans

Vision Service Plan (VSP)

The County elected to renew their vision plans with VSP for POA. The rates for the 2020 plan year are provided in section 1.

The VSP plans are entering the second year of a two-year rate guarantee. The plan will next renew January 1, 2021.

See **Exhibit G** for the 2020 VSP benefit summaries.

Dental Plans

Delta Dental of Oregon

The Incentive Plan is available to all employees.

Delta Dental proposed a three-year administrative fee agreement. The fee will increase by $0.06 PEPM effective January 1, 2020 and by $0.07 PEPM each of the next two renewals. The 2020 administration fee will be as follows:

Rates per Employee per Month	2019	2020	2021	2022
Administration fee	$6.49	$6.55	$6.62	$6.69
% Change		0.9%	1.0%	1.0%

There are no plan changes.

Exhibit I contains the Delta administrative contract changes for 2020 for POA.

See **Exhibit J** for the 2020 Delta benefit summaries.

Underwriting

Mercer projected a 2020 funding decrease of -4.7% for the 2020 self-insured dental plan. See **Exhibit H**.

Projections for the County's self-funded dental plans were based on 12 months of claims experience from July 1, 2018, through June 30, 2019. An annual trend factor of 5.0% and 3% margin were used.

Mercer recommended and the County accepted the 2020 funding rates provided in Section 1.

Kaiser Permanente

The County has a fully insured dental plan through Kaiser that is available to all employees. Kaiser proposed a 1.0% rate increase to the 2019 premium rates.

Exhibit E contains the 2020 standard contract changes provided by Kaiser, which will be effective January 1, 2020. See **Exhibit F** for the Kaiser 2020 benefit summaries.

The 2020 premium rates for Kaiser dental plan are shown in Section 1.

Life and Voluntary AD&D Insurance

MetLife

The County has basic life, AD&D, dependent life, and group universal life plans with MetLife. Mercer was able to negotiate a 30.6% decrease to the basic life rate. All other lines of coverage will receive no increase. The rates are effective through December 31, 2021.

A summary of the rates effective January 1, 2020 through December 31, 2021, are as follows:

Peace Officer Association

Basic Life	
Represented Employees	$0.136/$1,000
Dependent Life	
$2,000 per spouse/domestic partner or child	$0.38 PEPM

Long Term Disability Insurance

The Standard

The County offers two LTD plans through Standard as follows:

- **Base LTD Plans**
  - **POA.** This coverage is provided by the County without contributions from employees. The disability benefit is 60% of the first $3,333 of monthly pre-disability income. The plan is self-funded for the first 180 days of a disability and is fully insured starting on the 181st day of a disability.

- **Buy-up LTD Plans**
  - **Peace Officers.** This plan offers POA employees the option of buying additional disability coverage, equal to 60% of the next $6,667 of monthly pre-disability earnings above $3,333 up to a maximum of $10,000.

The buy-up LTD benefit plans for Peace Officers are 100% paid by employees on a pretax basis. The Plans have two funding components – self-funded and fully insured. Both components are administered by Standard.

The benefits will remain unchanged for the 2020 plan year.

Fees and Premium Rates

The County is entering the second year of a two-year rate guarantee with Standard. The next renewal will be January 1, 2021.

The 2020 funding, premium, and fees are as follows:

Self-Insured Plan	
Administration Fees	
General	$0.36 PEPM
New Claim	$390 per claim
Open Claim	$19 per open claim at month end
Incidental	As incurred
Insured Plan	
Base – Peace Officers	$0.30/$100
Buy-Up – Peace Officers	$0.34/$100

Employee Assistance Plan

Cascade Centers

The 2020 fee for EAP services is as follows:

Fee per Participant per Month	
Employee Assistance Program	$2.50

Flexible Spending Account Administrator

Navia Benefits Solutions

The County uses Navia Benefits Solutions (Navia), formerly Flex-Plan Services, to provide FSA plans. The County is entering the third year of a three-year rate guarantee with Navia effective through December 31, 2020.

The 2020 fees remain the same as the 2019 fees, as follows:

Fees per Participant per Month	
Health Care FSA	$5.00
Annual Maximum	$2,500
Dependent Care FSA	$5.00
Annual Maximum	$5,000

3

Employee Contributions

Peace Officers

The County pays 95% of the premium for the Providence medical plans. However, if the premium increases more than 10% in any one year, the County and the employees shall evenly split the increased costs above 10%. The County pays 100% of the premium for employees enrolled in the Kaiser medical plan.

	Employee Only	Employee w/ Spouse/Partner	Employee w/ Child(ren)	Employee w/ Family
Providence Personal Option				
Employer	$677.50	$1,448.50	$1,296.50	$2,222.50
Employee	$93.50	$93.50	$93.50	$93.50
Providence Open Option				
Employer	$725.10	$1,548.10	$1,386.10	$2,374.10
Employee	$99.90	$99.90	$99.90	$99.90
Kaiser				
Employer	$707.84	$1,415.70	$1,274.12	$2,123.54
Employee	$0.00	$0.00	$0.00	$0.00
HRA VEBA				
Cash Back	$176.00	$176.00	$176.00	$176.00

The County pays 100% of the premium for the Delta Dental of Oregon and Kaiser dental plans. The County removed the dental contribution for all employees. The Dental Opt Out cash back for all employees is as follows.

	Employee Only	Employee w/ Spouse/Partner	Employee w/ Child(ren)	Employee w/ Family
Dental Opt Out				
Cash Back	88.00	88.00	88.00	88.00

0119 to 0120 ASO Contract Comparison – Grandfathered Plans (GR)
Open Option and Personal Option
-INITIAL 09.20.19-

PROVIDENCE Health Plan

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Topic	Affected Material	Description	Current Language & Provisions (from existing 0119 documents)	New Language & Provisions (in new 0120 documents)	Benefit change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
ASO Handbook Changes (for all Plan types, except as otherwise denoted)								
Prior Authorization	All handbooks Personal Option book is section 3.7	Add new services to Prior Authorization List to reflect changes in PHP medical policy	**3.5 PRIOR AUTHORIZATION** ***** • All outpatient surgical procedures; ***** • All inpatient, residential and day, intensive outpatient, or partial hospitalization treatment Services for Mental Health and Substance Abuse, as provided in sections 4.10.1 and 4.10.2. *****	**3.5 PRIOR AUTHORIZATION** ***** • All outpatient surgical procedures; • Anesthesia Care with Diagnostic Endoscopy; ***** • All inpatient, residential ~~and~~, day, intensive outpatient, or partial hospitalization treatment Services for Mental Health and Chemical Dependency, as provided in sections 4.10.1 and 4.10.2; *****	Yes	No	Anesthesia Care with Diagnostic Endoscopy is being added to PHP's Prior Authorization List to reflect a change in PHP medical policy and to provide greater clarity on prior authorization requirements for Members. Remainder of changes are merely minor updates to wording to provide better clarity. No impact to benefits.	
Maternity Services	All handbooks	Updating definition of Women's Health Care Providers	**4.8 Maternity Services** ***** Women may choose to receive Maternity 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 obstetrical services), physician assistants and advanced registered nurse practitioners, certified nurse midwives, and licensed direct entry midwives. *****	**4.8 Maternity Services** ***** Women may choose to receive Maternity 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 obstetrical services), physician assistants and advanced registered nurse practitioners specializing in women's health care, certified nurse midwives, and licensed direct entry midwives. *****	No	No	Clarifying types of Women's Health Care Providers who can provide maternity care services.	

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Topic	Affected Material	Description	Current Language & Provisions (from existing 0119 documents)	New Language & Provisions (in new 0120 documents)	Benefit change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
Reconstructive Surgery	All handbooks	Language revised to comply with OAR 836-053-0012	**4.12.4 Reconstructive Surgery** Reconstructive Surgery is covered for conditions resulting from trauma, infection or other diseases and for congenital deformities and anomalies if there is a resultant functional impairment. Benefits are covered as those Services listed in the Benefit Summary based upon the type of Services received. For Restoration of Head or Facial Structures; Limited Dental Services, see section 4.12.6.	**4.12.4 Reconstructive Surgery** Reconstructive Surgery is covered for conditions resulting from ~~trauma, infection or other diseases and for congenital deformities and anomalies if there is a resultant functional impairment.~~congenital defects, developmental abnormalities, trauma, infection, tumors or disease. Reconstructive surgery may be performed to correct a functional impairment in which the special, normal or proper action of any body part or organ is damaged; when necessary because of accidental injury or to correct scars or defects from accidental injury; or when necessary to correct scars or defects to the head or neck resulting from covered surgery. Benefits are covered as those Services listed in the Benefit Summary based upon the type of Services received. For Restoration of Head or Facial Structures; Limited Dental Services, see section 4.12.6.	No	Yes OR state regulation only; no federal mandate	Additional language added to align with PHP policy and to comply with state regulations. This is not a federal mandated change or a federal definition. This change is based on requirements of Oregon DFR.	
Restoration of Head/Facial Structures; Limited Dental Services	All handbooks	Language revised to align with applicable laws and current medical policy:	**4.12.6 Restoration of Head/Facial Structures; Limited Dental Services** Covered Services are limited to those Services that are Medically Necessary for the purpose of controlling or eliminating pain, or restoring facial configuration or functions such as speech, swallowing or chewing. Medically Necessary Covered Services include	**4.12.6 Restoration of Head/Facial Structures; Limited Dental Services** Covered Services are limited to those Services that are Medically Necessary for the purpose of controlling or eliminating infection, controlling or eliminating pain, or restoring facial configuration or functions such as speech, swallowing or chewing~~.~~ but	No	Yes OR state regulation only; no federal mandate	Additional language added to align with PHP policy and to comply with state regulations. This is not a federal mandated change or a federal definition. This change is based on requirements of Oregon DFR.	

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Topic	Affected Material	Description	Current Language & Provisions (from existing 0119 documents)	New Language & Provisions (in new 0120 documents)	Benefit change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
		Treatment of Craniofacial Anomaly (ORS 743A.150) and Maxillofacial Prosthetic Services (ORS 743A.148)	restoration and management of head and facial structures, including teeth, dental implants and bridges, that cannot be replaced with living tissue and that are defective because of trauma, disease or birth or developmental deformities, not including malocclusion of the jaw. ***** Exclusions that apply to Covered Services include: ***** • The making or repairing of dentures; • Orthognathic surgery to shorten or lengthen the upper or lower jaw, unless related to a traumatic injury or to a neoplastic or degenerative disease; and	not including cosmetic services to improve on the normal range of conditions. Medically Necessary Covered Services include restoration and management of head and facial structures, including teeth, dental implants and bridges, that cannot be replaced with living tissue and that are defective because of trauma, disease or birth or developmental deformities, not including overbite, crossbite, malocclusion or similar developmental irregularities of the teeth or jaw. ***** Exclusions that apply to Covered Services include: ***** • The making or repairing of dentures; • Orthognathic surgery to ~~shorten~~treat developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or ~~lengthen~~similar developmental irregularities of the ~~upper or lower jaw, unless related to a traumatic~~				

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Topic	Affected Material	Description	Current Language & Provisions (from existing 0119 documents)	New Language & Provisions (in new 0120 documents)	Benefit change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
			• Services to treat temporomandibular joint syndrome, except as specified in section 4.12.7. *****	~~injury or to a neoplastic or degenerative disease~~teeth; and • Services to treat temporomandibular joint syndrome, including orthognathic surgery, except as specified in section 4.12.7. *****				
Hearing Loss Services	All handbooks	Language added to further clarify the 2019 Oregon state mandate for hearing loss coverage	**4.9.5 State Mandated Hearing Aid Benefit** ***** **Definitions:** ***** **Hearing Aid** Hearing Aid means any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments, batteries, or accessory for the instrument or device, except batteries and cords. ***** **Cochlear implants:** Cochlear implants for one or both ears, including programming and reprogramming expenses. Cochlear Implants require Prior Authorization. The devices are covered under the Surgery and applicable Facility benefit.	~~4.9.5~~4.12.11 Hearing Loss Services~~State Mandated Hearing Aid Benefit~~ ***** **Definitions:** ***** **Hearing Aid** Hearing Aid means any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments, batteries, or accessory for the instrument or device, except ~~batteries and~~ cords. ***** **Cochlear implants:** Cochlear implants for one or both ears, including programming ~~and~~ reprogramming, replacement and repair expenses. Cochlear Implants require Prior Authorization. The devices are covered under the Surgery and applicable Facility benefit.	No	Yes OR state reg only; no federal mandate	These changes only apply to ASO groups which adopted the full Oregon state hearing loss benefit mandate for 2019. These edits merely serve to clarify the scope of coverage required by the 2019 Oregon state hearing loss mandate. Language changes in the 2019 column reflect client's current POA configuration for this benefit.	

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Topic	Affected Material	Description	Current Language & Provisions (from existing 0119 documents)	New Language & Provisions (in new 0120 documents)	Benefit change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
			Hearing aids & related accessories: Medically Necessary external hearing aids and devices are covered for Members one per ear every three Calendar Years. Hearing aids and devices are covered under the Medical Appliances benefit. **Diagnostic & Treatment Services** Medically Necessary diagnostic and treatment services, including office visits for hearing tests appropriate for member's age or development need, hearing aid checks, and aided testing. Services are covered under the applicable benefit level for the service received. For example, office visits with an audiologist are covered under the Specialist office visit benefit.	**Hearing aids & related accessories:** Medically Necessary external hearing aids and devices are covered for Members one per ear every three Calendar Years. Hearing aids and devices are covered under the Medical Appliances benefit. Hearing aid batteries are covered for one box per hearing aid per Calendar Year. **Diagnostic & Treatment Services** Medically Necessary diagnostic and treatment services, including office visits for hearing tests appropriate for member's age or development need, hearing aid checks, and aided testing. Services are covered under the applicable benefit level for the service received. For example, office visits with an audiologist are covered under the Specialist office visit benefit. **Hearing Assistance Technology:** • Bone conduction sound processors, if necessary for appropriate amplification of hearing loss. This benefit is available once every 3 Calendar Years for all Members. • Hearing assistive technology systems, if necessary, for				

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				appropriate amplification of hearing loss. This benefit is available once every 3 Calendar Years for all Members. **Limits to Hearing Loss Services** Coverage for hearing loss services are provided in accordance with state and federal law. ~~Please contact Customer Service for specific coverage requirements.~~				
Exclusions	All handbooks	Adding new standard exclusions and streamlining language used across lines of business handbooks	**5. EXCLUSIONS** ***** **General Exclusions:** **We do not cover Services and supplies which:** ***** • Are provided by or payable under any plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law; ***** • Are provided for convenience, educational or vocational purposes including, but not limited to, videos and books, educational programs to which drivers are referred by the	**5. EXCLUSIONS** ***** **General Exclusions:** **We do not cover Services and supplies which:** ***** • Are provided by or payable under any health plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law; ***** • Are provided for convenience, educational or vocational purposes including, but not limited to, videos ~~and~~, books~~,~~ and educational programs to which drivers are	No	No	See rationales explained below:	

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Topic	Affected Material	Description	Current Language & Provisions (from existing 0119 documents)	New Language & Provisions (in new 0120 documents)	Benefit change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
			judicial system, and volunteer mutual support groups; ***** • Are payable under any automobile medical, personal injury protection, automobile no-fault, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance makes benefits or Services available to you, whether or not you make application for such benefits or Services and whether or not you are refused payment for failure to satisfy any term of such coverage. If such coverage is required by law and you unlawfully fail to obtain it, benefits will be deemed to have been payable to the extent of that requirement. This exclusion also applies to charges applied to the deductible of such contract or insurance. Any benefits or Services provided under this Plan that are subject to this exclusion are provided solely to assist you and such assistance does not waive our right to reimbursement or subrogation as specified in section 6.3. This exclusion also applies to	referred by the judicial system and volunteer mutual support groups; ***** • Are payable under any automobile medical, personal injury protection~~,~~ (PIP), automobile no-fault, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance makes benefits or Services available to you, whether or not you make application for such benefits or Services and whether or not you are refused payment for failure to satisfy any term of such coverage. If such coverage is required by law and you unlawfully fail to obtain it, benefits will be deemed to have been payable to the extent of that requirement. This exclusion also applies to charges applied to the Deductible of such contract or insurance. Any benefits or Services provided under this Plan that are subject to this exclusion are provided solely to assist you and such assistance does not waive our right to reimbursement or subrogation as specified in section				

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			Services and supplies after you have received proceeds from a settlement as specified in section 6.3.3; ***** **The Plan does not cover:** • Charges that are in excess of Usual, Customary and Reasonable (UCR) costs; ***** • Sales taxes, handling fees and similar surcharges, as explained in the definition of UCR; and ***** **Exclusions that apply to Reproductive Services:** *****	6.3. This exclusion also applies to Services and supplies after you have received proceeds from a settlement as specified in section 6.3.3; ***** **The Plan does not cover:** • Charges that are in excess of the Usual, Customary and Reasonable (UCR) ~~costs~~charges; ***** • Sales taxes, handling fees and similar surcharges, as explained in the definition of UCR; ~~and~~ ***** • All Direct-to-Consumer testing products; and • Dance, poetry, music or art therapy, except as part of an approved treatment program. ***** **Exclusions that apply to Reproductive Services:** ***** • Termination of pregnancy, unless there is a severe threat to the	----------		_____ Additional bullet point added to clarify direct-to-consumer testing exclusions, per PHP medical policy. _____	

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			• Termination of pregnancy, unless there is a severe threat to the mother, or if the life of the fetus cannot be sustained; • Reversal of voluntary sterilization; • Condoms and other over-the-counter birth control products; and • Services provided in a premenstrual syndrome clinic or holistic medicine clinic.	mother, or if the life of the fetus cannot be sustained; • Reversal of voluntary sterilization; • Male condoms and other over-the-counter birth control products for men; and • Services provided in a premenstrual syndrome clinic or holistic medicine clinic.			Language added to clarify that condom and OTC birth control exclusion only applies to men.	
General Language/Miscellaneous Changes								
Introduction	All handbooks	Streamlining language used across lines of business handbooks	**1.1 KEY FEATURES OF YOUR OPEN OPTION GRANDFATHERED PLAN** ***** ➢ A printable directory of Network Providers is available at http://phppd.providence.org/. Members without Internet access or who would like a hard copy of our Provider Directory may contact Customer Service for assistance. ➢ **Certain Covered Services require an approved Prior Authorization, as specified in section 3.5.** ➢ Coverage limitations and exclusions apply to certain Services, as stated in sections 3, 4, and 5 and the Benefit Summary.	**1. KEY FEATURES OF YOUR OPEN OPTION GRANDFATHERED PLAN** ***** ➢ A printable directory of In-Network Providers in our Service Area and our national In-Network Providers is available at [http://phppd.providence.org/]. Members without Internet access or who would like a hard copy of our Provider Directory may contact Customer Service for assistance. ➢ **Certain Covered Services require an approved Prior Authorization, as specified in section 3.5.** ➢ Coverage limitations and exclusions apply to certain Services, as stated in	No	No	Minor language change to establish consistency across all PHP handbooks.	

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			*****	sections 3, 4, ~~and~~ 5 and your Benefit Summary(ies). *****				
Introduction	All handbooks	Streamlining language used across lines of business handbooks	**2.1 YOUR [PLAN NAME]** ***** **It is your responsibility to verify whether or not a physician/provider, Hospital or other facility is participating with Providence Health Plan, and whether or not the health care is a Covered Service even if you have been directed or referred for care by a Network Provider.** If you are unsure about a physician/provider's, Hospital's or other facility's participation with Providence Health Plan, visit the Provider Directory, available online at http://phppd.providence.org/, before you make an appointment. You also can call Customer Service to get information about a provider's participation with Providence Health Plan and your benefits. *****	**2.1 YOUR [PLAN NAME]** ***** **It is your responsibility to verify whether or not a physician/provider, Hospital or other facility is ~~participating with Providence Health Plan~~ an In-Network Provider, and whether or not the health care is a Covered Service even if you have been directed or referred for care by an In-Network Provider.** If you are unsure about a physician/provider's, Hospital's or other facility's participation with Providence Health Plan, visit ~~the~~our Provider Directory, available online at ~~ProvidenceHealthPlan.com,~~[http://phppd.providence.org/], before you make an appointment. You can also ~~can~~ call Customer Service to get information about a provider's participation with Providence Health Plan and your benefits. *****	No	No	Minor language change to establish consistency across all PHP handbooks.	
Wellness Benefits	All handbooks	Add language addressing health coaching and	**2.7 WELLNESS BENEFITS** ***** **Health education classes**	**2.7 WELLNESS BENEFITS** ***** **Health education classes**	No	Yes	Health coaching and Care management benefit language added to reflect existing wellness benefit services available to members.	

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		care management wellness benefits	Members may receive discounts on health education classes supporting smoking cessation, childbirth education and weight management You can access by calling the Providence Resource Line at 800-562-8964 or visiting www.providence.org/classes.	Members may receive discounts on health education classes supporting smoking cessation, childbirth education and weight management You can access by calling the Providence Resource Line at [800-562-8964] or visiting [www.providence.org/classes]. **Providence Health Coaching** Members can receive free coaching support for weight loss, diabetes prevention, nutrition, stress management, exercise, sleep and tobacco cessation. You can access by calling [503-574-6000] (TTY: [711]) or [888-819-8999] or visiting [www.ProvidenceHealthPlan.com/healthcoach]. **Providence Care Management** Members can receive information and assistance with healthcare navigation and managing chronic conditions from a Registered Nurse Care Manager.			DFR requires that we explicitly disclose this per ORS 746.035. Note: This change only applies to the groups that have Health Coaching benefits and/or Care Management benefits.	

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			*****	You can access by calling 800-662-1121 or emailing caremanagement@providence.org. *****				
Privacy of member information	All handbooks	Revising language to better reflect how we protect member information	**2.8 PRIVACY OF MEMBER INFORMATION** At Providence Health Plan, we respect the privacy and confidentiality of your protected health information (PHI). Providence Health Plan takes great care to determine when it is appropriate to share your PHI, in accordance with federal and state privacy laws. Providence Health Plan may use protected health information and may share it with others as part of your treatment, payment for your treatment, and our business operations.	**2.8 PRIVACY OF MEMBER INFORMATION** At Providence Health Plan, we respect the privacy and confidentiality of your protected health information. ~~Providence Health Plan takes great care to determine when it is appropriate to share your PHI, in accordance with federal and state privacy laws. We use protected health information and may share it with others as part of your treatment, payment for your treatment, and our business operations.~~We are required by law to maintain the privacy of your protected health information, (commonly called PHI or your personal information) including in electronic format. When we use the term "personal information," we mean information that identifies you as an individual (such as your name and Social Security Number, as well as financial, health and other information about you that is nonpublic), which we obtain so we can provide you with the benefits and coverage under your Employer's plan. Providence Health Plan maintains policies that protect the confidentiality of personal information, including Social Security numbers, obtained	No	No	Revision to Privacy language for clarification of how member personal information is protected by PHP.	

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			The following are ways Providence Health Plan may use or share information about you, consistent with law: • We will use the information to administer your benefits and help pay your medical bills that have been submitted to us for payment. • We may share your information with your doctors or Hospitals to help them provide medical care to you (e.g., if you are in the Hospital, we may give them access to any medical records sent to us by your doctor). • We may use or share your information with others to help manage your health care (e.g., we might talk to your doctor to suggest a disease management or wellness program that could help improve your health). • We may share your information with individuals who perform business functions for us. We will only share your information if there is a business need to do so and if our business partner agrees to protect the information.	from its Members in the course of its regular business functions. ~~The following are ways we may use or share information about you, consistent with law:~~ • ~~We will use the information to administer your benefits and help pay your medical bills that have been submitted to us for payment.~~ • ~~We may share your information with your doctors or Hospitals to help them provide medical care to you (e.g., if you are in the Hospital, we may give them access to any medical records sent to us by your doctor).~~ • ~~We may use or share your information with others to help manage your health care (e.g., we might talk to your doctor to suggest a disease management or wellness program that could help improve your health).~~ • ~~We may share your information with individuals who perform business functions for us. We will only share your information if there is a business need to do so and if our business partner agrees to protect the information.~~				

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			• We may use your information to provide you with information about alternative medical treatments and programs or about health related products and services that you may be interested in (e.g., we sometimes send out newsletters that let you know about "healthy living" alternatives such as smoking cessation or weight loss programs). Providence Health Plan makes every effort to release only the minimum amount of information necessary to meet any release requirement and only release information on a need to know basis. Also, wherever feasible, identifiable information is removed from any information shared. To secure the confidentiality of medical information, Providence Health Plans has procedures in place which you can review at www.ProvidenceHealthPlan.com/privacy. When Member information is used in health studies, identifiable information is not released. All Member-specific information has identifying information removed, and aggregated data are used as early in the measurement process as possible. The	~~• We may use your information to provide you with information about alternative medical treatments and programs or about health related products and services that you may be interested in (e.g., we sometimes send out newsletters that let you know about "healthy living" alternatives such as smoking cessation or weight loss programs).~~ ~~We make every effort to release only the minimum amount of information necessary to meet any release requirement and only release information on a need to know basis. Also, wherever feasible, identifiable information is removed from any information shared.~~ ~~To secure the confidentiality of medical information, we have procedures in place which you can review at ProvidenceHealthPlan.com/privacy.~~ ~~When Member information is used in health studies, identifiable information is not released. All Member-specific information has identifying information removed, and aggregated data are used as early in the measurement process as possible. The~~				

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			privacy of our Members is completely protected. Our agreements with Network Providers contain confidentiality provisions that require providers treat your personal health information with the same care. You have the right to ask us to restrict how we use or disclose your information for treatment, payment or health care operations. You also have the right to ask us to restrict information we may give to persons involved in your care. While we may honor your request for restrictions, we are not required to agree to these restrictions. You have the right to ask us to redirect and send your own personal protected health information to you only and directly as permitted by current privacy laws. You also have the right to register a complaint if you believe your privacy is compromised in any manner. Members may request to see their medical records. Call your physician's or provider's office to ask how to schedule a visit for this purpose.	~~privacy of our Members is completely protected.~~ ~~Our agreements with Network Providers contain confidentiality provisions that require providers treat your personal health information with the same care.~~ ~~You have the right to ask us to restrict how we use or disclose your information for treatment, payment or health care operations. You also have the right to ask us to restrict information we may give to persons involved in your care. While we may honor your request for restrictions, we are not required to agree to these restrictions. You have the right to ask us to redirect and send your own personal protected health information to you only and directly as permitted by current privacy laws. You also have the right to register a complaint if you believe your privacy is compromised in any manner.~~ Members may request to see or obtain their medical records~~.~~ from their provider. Call your physician's or provider's office to ask how to ~~schedule a visit for this purpose~~receive a copy.				

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			For more information about uses and disclosures of Member information, including uses and disclosures required by law, please refer to our Notice of Privacy Practices. A copy is available at www.ProvidenceHealthPlan.com/privacy or by calling Customer Service. ***** **Confidentiality and your Employer** In accordance with the federal privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), Providence Health Plan will not disclose a Member's protected health information (PHI) to the Employer or any agent of the Employer unless requested for the HIPAA allowed purpose of the Employer's obtaining bids from other health plans for further health coverage or for the Employer's modifying, amending, or terminating any benefit under the health plan. Although allowable by HIPAA, Providence Health Plan's practice is to deidentify, or masks personal identifiers, on claims data released for these purposes.	For more information about uses and disclosures of Member information, including uses and disclosures required by law, please refer to our Notice of Privacy Practices. A copy is available at ~~ProvidenceHealthPlan.com/privacy~~https://healthplans.providence.org/members/rights-notices or by calling Customer Service. ***** **Confidentiality and your Employer** In accordance with the federal privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), Providence Health Plan will not disclose a Member's protected health information (PHI) to the Employer or any agent of the Employer unless requested for the HIPAA allowed purpose of the Employer's obtaining bids from other health plans for further health coverage or for the Employer's modifying, amending, or terminating any benefit under the health plan. ~~Although allowable by HIPAA~~In these circumstances, Providence Health ~~Plan's practice~~Plan may release summary health information, which is ~~to deidentify, or masks personal~~PHI from which your name, ID number, dates smaller than a year, and certain other identifiers~~, on claims data~~				

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				~~released for these purposes~~ have been removed. ~~In all other circumstances,~~ Providence Health Plan ~~does not~~may disclose a Member's PHI to an Employer or any agent of the Employer~~, Should Providence Health Plan change this practice, a Member's PHI would not be released to an Employer or any agent of~~ if the ~~Employer unless Providence Health Plan determines that such~~ disclosure is: 1. In compliance with the applicable provisions of HIPAA; and 2. ~~Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer, under which the Employer agrees to limit further disclosures to those permitted by law and plan documents, to ensure that any person or subcontractor with whom the PHI is disclosed makes similar agreements, not to use PHI for employment-related actions or decisions, not to use PHI for purposes related to any other benefits, to provide access to~~				
			In all other circumstances, Providence Health Plan does not disclose a Member's PHI to an employer or any agent of the Employer, Should Providence Health Plan change this practice, a Member's PHI would not be released to an Employer or any agent of the Employer unless Providence Health Plan determines that such disclosure is: 1. In compliance with the applicable provisions of HIPAA; and 2. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer, under which the Employer agrees to limit further disclosures to those permitted by law and plan documents, to ensure that any person or subcontractor with whom the PHI is disclosed makes similar agreements, not to use PHI for employment-related actions or decisions, not to use PHI for purposes related to any other benefits, to provide access to individuals to their PHI except as					

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			limited by law, to amend PHI as provided by law, to account for access to and disclosures of PHI as provided by law, to provide Providence Health Plan information Providence Health Plan may need to provide individuals with accountings of disclosures, to be audited by the US Department of Health & Human Services as to its handling of PHI, to return all PHI to Providence Health Plan when no longer required, to identify employees or classes of employees that need access to PHI and to prevent access to PHI for employees or classes of employees who are not identified as needing access to PHI, and to report to Providence Health Plan any violations of these principles. An Employer who receives PHI from Providence Health Plan must maintain policies and procedures that demonstrate compliance with the foregoing expectations, including procedures for the return, destruction and restriction of further use of PHI, and procedures for taking action if employees or	~~individuals to their PHI except as limited by law, to amend PHI as provided by law, to account for access to and disclosures of PHI as provided by law, to provide Providence Health Plan information Providence Health Plan may need to provide individuals with accountings of disclosures, to be audited by the US Department of Health & Human Services as to its handling of PHI, to return all PHI to Providence Health Plan when no longer required, to identify employees or classes of employees that need access to PHI and to prevent access to PHI for employees or classes of employees who are not identified as needing access to PHI, and to report to Providence Health Plan any violations of these principles. An Employer who receives PHI from Providence Health Plan must maintain policies and procedures that demonstrate compliance with the foregoing expectations, including procedures for the return, destruction and restriction of further use of PHI, and procedures~~				

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			subcontractor's inappropriately use or disclose PHI. Providence Health Plan will disclose a Member's PHI with whom and in ways permitted by HIPAA. These uses are covered in detail in Providence Health Plan's Notice of Privacy Practices available online, or by mail if you request it. Providence Health Plan will only use or disclose a Member's PHI for treatment purposes, operational purposes,	~~for taking action if employees or subcontractor's inappropriately use or disclose PHI.~~ 2. Due to a HIPAA-compliant authorization, the Member has completed to allow the Employer access to the Member's PHI; or 3. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer. The details of this required certification can be reviewed at https://healthplans.providence.org/about-us/privacy-notices-policies/protected-health-information-and-your-employer/. Providence Health Plan will disclose a Member's PHI with whom and in ways permitted by HIPAA. These uses are covered in detail in Providence Health Plan's Notice of Privacy Practices available online, or by mail if you request it. ~~Providence Health Plan will only use or disclose a Member's PHI for treatment purposes, operational purposes, payment purposes, or for any~~				

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			payment purposes, or for any reasonable purposes to which the Member has consented.	~~reasonable purposes to which the Member has consented.~~				
In-Network Providers	All handbooks	Switching out description of service area to generic service area terminology. Streamlining language used across lines of business handbooks	**3.1 IN-NETWORK PROVIDERS** Providence Health Plan has contractual arrangements with certain physicians/providers, hospitals and facilities located in Oregon and southwest Washington, as well as Nationwide. Our agreements with these "Participating Providers" enable you to receive quality health care for a reasonable cost. **For Services to be covered using your In-Plan benefit, you must receive Services from In-Network Providers. It is your responsibility to verify whether or not a physician/provider, hospital or other facility is participating with us even if you have been directed or referred for care by a Network Provider.**	**3.1 IN-NETWORK PROVIDERS** Providence Health Plan has contractual arrangements with certain physicians/providers, hospitals and facilities located in ~~Oregon and southwest Washington~~. Our agreements with these "In Network Providers" enable you to receive quality health care for a reasonable cost. **For Services to be covered, you must receive Services from In Network Providers. It is your responsibility to verify whether or not a physician/provider, hospital or other facility an In-Network Provider ~~is participating with us~~ even if you have been directed or referred for care by an In Network Provider.**	No	No	Removal of state specific service area language to establish language consistency across all PHP handbooks. Minor language change to streamline language across handbooks.	
Service provided by Out-Of-Network providers	All handbooks	Streamlining language used across lines of business handbooks	**3.3 SERVICES PROVIDED BY OUT OF NETWORK PROVIDERS** ***** **Some Services are only covered under your In-Plan benefit**: • Virtual Visits (see section 4.3.2). • E-mail Visits (see section 4.3.3).	**3.3 SERVICES PROVIDED BY OUT OF NETWORK PROVIDERS** ***** **Some Services are only covered under your In-Network benefit:** • Virtual Visits (see section 4.3.2). • E-mail Visits (see section 4.3.3). • Temporomandibular Joint (TMJ) Services (see section 4.12.7).	No	No	Minor language change to streamline language across handbooks.	

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			• Temporomandibular Joint (TMJ) Services (see section 4.12.7). • Tobacco Use Cessation Services (see section 4.1.8). • Human Organ/Tissue Transplants (see section 4.13). • Any item listed in your Benefit Summary as "Not Covered" Out-of-Plan. *****	• Tobacco Use Cessation Services (see section 4.1.8). • Retail Health Clinic Visits (see section 4.3.8); • Human Organ/Tissue Transplants (see section 4.13); and • Any item listed in your Benefit Summary as "Not Covered" under Out-of-Network Plan. *****				
Prior Authorization	All handbooks Personal Option section 3.7	Streamlining language used across lines of business handbooks	**3.5 PRIOR AUTHORIZATION** While Prior Authorization is a requirement for coverage of certain Services under this Plan, Prior Authorization is not a treatment directive. The actual course of medical treatment that a Member chooses remains strictly a matter between the Member and the provider and is separate from the Prior Authorization requirements of this Plan. Prior Authorization is not a guarantee of benefit payment under this Plan and Prior Authorization does not supersede other specific provisions of this Plan regarding coverage, limitations, exclusions and Medical Necessity. *****	**3.5 PRIOR AUTHORIZATION** While Prior Authorization is a requirement for coverage of certain Services under this Plan, Prior Authorization is not a treatment directive. The actual course of medical treatment that a Member chooses remains strictly a matter between the Member and the provider and is separate from the Prior Authorization requirements of this Plan. Prior Authorization is not a guarantee of benefit payment under this Plan and a Prior Authorization determination does not supersede other specific provisions of this Plan regarding coverage, limitations, exclusions and Medical Necessity. *****	No	No	Minor language change to correct title to section. This change only applies to ASO groups who have separate OOP maximum language in their handbooks.	
Understanding Out-of-	Open Option	Correcting section title	**3.11.2 Understanding Out-of-Pocket Maximums** *****	**3.11.2 Understanding Out-of-Pocket Maximums** *****	No	No	Minor language change to correct title to section.	

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Pocket Maximums			***Common In-Plan and Out-of-Plan Out-of-Pocket Maximum:*** Your Plan has a Common In-Plan and Out-of-Plan Out-of-Pocket Maximum, as listed in your Benefit Summary. The Common Out-of-Pocket Maximum can be met by payments you make for Covered Services using In-Plan and Out-of-Plan benefits. *****	***Common In-Network and Out-of-Network Out-of-Pocket Maximums:*** If your plan has a Common In-Network and Out-of-Network Out-of-Pocket Maximum, it will be listed in your Benefit Summary. The Common In-Network and Out-of-Network Out-of-Pocket Maximum can be met by payments you make for Covered Services using In-Network and Out-of-Network benefits. *****			This change only applies to ASO groups who have separate OOP maximum language in their handbooks.	
Allergy Shots, Allergy Serums and Injectable Medications	All handbooks	Modify injectable and infusion drug language for clarity	**4.3.5 Allergy Shots, Allergy Serums and Injectable Medications** Allergy shots, allergy serum, injectable medications, and total parenteral nutrition (TPN) received in your Provider's office are covered as shown in your Benefit Summary. Therapy and testing for treatment of allergies including, but not limited to, Services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment are covered only when such therapy or testing is approved by the American Academy of Allergy and Immunology, or the Department of Health and Human Services or any of its offices or agencies. Some injectable medications may require Prior Authorization, as listed in the Medical benefit drug prior authorization list	**4.3.5 Allergy Shots, Allergy Serums ~~and~~, Injectable and Infused Medications** Allergy shots, allergy serum, injectable medications and total parenteral nutrition (TPN) received in your Provider's office are covered, as shown in your Benefit Summary. Therapy and testing for treatment of allergies including, but not limited to, Services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment are covered only when such therapy or testing is approved by the American Academy of Allergy and Immunology, or the Department of Health and Human Services or any of its offices or agencies. Some injectable medications may require Prior Authorization, as listed in the	No	No	Additional language added to provide members clarification on injectable and infused medication coverage and to align with PHP pharmacy policy.	

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			available on our website at https://healthplans.providence.org/members/pharmacy-resources/Pages/default.aspx or by calling Customer Service. See section 4.7.1 for coverage of infusion at Outpatient Facilities.	Medical benefit drug prior authorization list available on our website at [https://healthplans.providence.org/members/pharmacy-resources/Pages/default.aspx] or by calling Customer Service. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. See section 5.9.1 for coverage of infusion at Outpatient Facilities.				
Emergency Care	All handbooks	Streamlining language used across lines of business handbooks	**4.5.1 Emergency Care** ***** When you are admitted to an Out-of-Network Hospital from the emergency room, your Inpatient Services are covered under your In-Network benefit until your condition becomes stable. Once your condition is stabilized, Providence Health Plan will work with you to arrange transfer to an In-Network facility. This process is called "repatriation." If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will be subject to your Out-of-Network benefits. *****	**4.5.1 Emergency Care** ***** When you are admitted to an Out-of-Network Hospital from the emergency room, your Inpatient Services are covered under your In-Network benefit until your condition becomes stable. Once your condition is stabilized, Providence Health Plan will work with you to arrange transfer to an In-Network facility. This process is called "repatriation." If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will be subject to your Out-of-Network benefits.	No	No	Minor language change to streamline language across handbooks. Additional language to clarify existing policy on how repatriation is covered, what will apply to In-Network and Out-of-Network coverage and how refusing transfer once stabilized affects coverage.	

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				Costs for non-emergency medical transport to facilitate repatriation to an In-Network facility are covered in full. *****			Additional language added to clarify costs are covered in full for non-emergency transportation to an In-Network facility in repatriation cases.	
Urgent Care	All handbooks	Streamlining language used across lines of business handbooks	**4.5.5 URGENT CARE** ***** When you are admitted to an Out-of-Network Hospital from an urgent care facility, your Inpatient Services are covered under your In-Network benefit until your condition becomes stable. Once your condition is stabilized, Providence Health Plan will work with you to arrange transfer to an In-Network facility. This process is called "repatriation." If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will not be covered. *****	**4.5.5 URGENT CARE** ***** When you are admitted to an Out-of-Network Hospital from an urgent care facility, your Inpatient Services are covered under your In-Network benefit until your condition becomes stable. Once your condition is stabilized, Providence Health Plan will work with you to arrange transfer to an In-Network facility. This process is called "repatriation." If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will not be covered. Costs for non-emergency medical transport to facilitate repatriation to an In-Network facility are covered in full. *****	No	No	Minor language change to streamline language across handbooks. Additional language added to clarify costs are covered in full for non-emergency transportation to an In-Network facility in repatriation cases.	

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Inpatient Hospital Services	All handbooks	Additional language to clarify the examples	**4.6.1 Inpatient Hospital Services** ***** Only Medically Necessary hospital services are covered. Covered inpatient Services received in a Hospital are: • Acute (inpatient) care; • A semi-private room (unless a private room is Medically Necessary); • Coronary care and intensive care; • Isolation care; and • Hospital services and supplies necessary for treatment and furnished by the Hospital, such as operating and recovery rooms, anesthesia, dressings, medications, whole blood and blood products, oxygen, X-ray, and laboratory Services during the period of inpatient hospitalization. (Personal items such as guest meals, slippers, etc., are not covered.) *****	**4.6.1 Inpatient Hospital Services** ***** Only Medically Necessary Hospital Services are covered. Covered inpatient Services received in a Hospital are: • Acute (inpatient) care; • A semi-private room (unless a private room is Medically Necessary); • Coronary care and intensive care; • Isolation care; and • Hospital Services and supplies necessary for treatment and furnished by the Hospital, such as use of the operating and recovery rooms, anesthesia, dressings, medications, whole blood and blood products, oxygen, X-ray, and laboratory Services during the period of inpatient hospitalization. (Personal items such as guest meals, slippers, etc., are not covered.) *****	No	No	Minor language change to streamline language across handbooks.	
Outpatient Services: Surgery, Dialysis, Infusion, Chemotherap	All handbooks Section reference	Streamlining language used across lines of business handbooks	**4.7.1 Outpatient Services: Surgery, Dialysis, Infusion, Chemotherapy and Radiation Therapy** Benefits are provided as shown in the Benefit Summary and include Services at a Hospital-based Outpatient Surgical Facility or an	**4.7.1 Outpatient Services: Surgery, Dialysis, Infusion, Chemotherapy and Radiation Therapy** Benefits are provided as shown in the Benefit Summary and include Services at a Hospital-based Outpatient Surgical Facility	No	No	Additional language added to provide members clarification on injectable and infused medication coverage and to align with PHP pharmacy policy.	

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y and Radiation Therapy	for PA is 3.5 in Open Option HBK.	Additional sentence to clarify injectable and infused medication access. Aligns with pharmacy cost saving initiatives. .	Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, and therapeutic procedures as ordered by your Qualified Practitioner. The Plan may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, Providence Health Plan will not Prior Authorize the Services. For additional information about Prior Authorization, see section 3.5. *****	or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, and therapeutic procedures as ordered by your Qualified Practitioner. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. The Plan may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, Providence Health Plan will not Prior Authorize the Services. For additional information about Prior Authorization, see section 3.5. ***** *****				
Outpatient Rehabilitative Services	All handbooks Section reference for PA is	Streamlining language used across lines of business handbooks	**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 shown in the Benefit Summary, to restore or improve lost function following illness or injury.	**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, ~~shown~~stated in the Benefit Summary, to restore or			Minor language change in 4.7.2 to streamline language across handbooks. Additional language added to indicate all services for Outpatient Rehabilitative Services are subject to review for Medical Necessity.	

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	3.5 in Open Option HBK.	Add language for reviewing services for medical necessity	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 Covered Services. (See section 4.6.3 for coverage of Inpatient Rehabilitative Services.) Covered Services under this benefit do **NOT** include: • Chiropractic adjustments and manipulations of any spinal or bodily area; • Exercise programs; • Rolfing, polarity therapy and similar therapies; and • Rehabilitation services provided under an authorized home health care plan as specified in section 4.11. ******	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 Covered Services. (See section 4.6.3 for coverage of Inpatient Rehabilitative Services.). All Services are subject to review for Medical Necessity. Covered Services under this benefit do **NOT** include: • Chiropractic adjustments and manipulations of any spinal or bodily area; • Exercise programs; • Rolfing, polarity therapy and similar therapies; and • Rehabilitation services provided under an authorized home health				

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				care plan as ~~specified~~stated in section 4.11. *****				
Outpatient Habilitative Services	All handbooks	Add language for reviewing services for medical necessity Streamlining language used across lines of business handbooks	**4.7.3 Outpatient Habilitative Services** Coverage is provided for Medically Necessary outpatient habilitative Services for maintenance, learning or improving skills and function for daily living. All Services must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. Coverage is provided at the same benefit level as Outpatient Rehabilitative Care listed in your Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 4.6.4 for coverage of Inpatient Habilitative Services.)	**4.7.3 Outpatient Habilitative Services** Coverage is provided, as stated in the Benefit Summary, for Medically Necessary outpatient habilitative Services for maintenance, learning or improving skills and function for daily living. All Services are subject to review for Medical Necessity and must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. Coverage is provided at the same benefit level as Outpatient Rehabilitative Care listed in your Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 4.6.4 for coverage of Inpatient Habilitative Services.)	No	No	Additional language added to reference Benefit Summary for coverage on outpatient habilitative services. Additional language added to indicate all services for Outpatient Rehabilitative Services are subject to review for Medical Necessity.	
Medical Supplies	Personal Option	Language added to call out hearing assistance technology coverage for members	**4.9.2 Medical Appliances** ***** 5. Medical devices that are surgically implanted into the body to replace or aid function (including bilateral cochlear implants). If you receive a procedure to implant a medical	**4.9.1 Medical Appliances** ***** 5. Medical devices that are surgically implanted into the body to replace or aid function (including bilateral cochlear implants). If you receive a procedure to implant a medical	No	No	Minor language change to streamline language across handbooks. Hearing assistive technology (HAT) coverage language added to include HATs appliances under Medically Necessary benefits.	

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		Streamlining language used across lines of business handbooks	device, you will be responsible for any Copayment or Coinsurance for the medical device in additional to any Copayment or Coinsurance for the procedure. 6. Other Medically Necessary appliances as ordered by your Qualified Practitioner. *****	device, you will be responsible for any Copayment or Coinsurance for the medical device ~~additional~~addition to any Copayment or Coinsurance for the procedure. 6. Other Medically Necessary appliances, including Hearing Aids and Hearing Assisted Technology (HAT), as ordered by your Qualified Practitioner. *****				
Durable Medical Equipment	All handbooks	Streamlining language used across lines of business handbooks	**4.9.4 Durable Medical Equipment (DME)** Benefits are provided for DME as shown in the Benefit Summary. Covered Services include Medically Necessary equipment such as a hospital bed, non-motorized wheelchair, ventilator, and similar equipment as approved by Providence Health Plan. *****	**4.9.4 Durable Medical Equipment (DME)** Benefits are provided for DME as shown in the Benefit Summary. Covered Services may include Medically Necessary equipment such as a hospital bed, non-motorized wheelchair, ventilator, and similar equipment as approved by Providence Health Plan.*****	No	No	Minor language change to streamline language across handbooks.	
Mental Health Services	All handbooks	Streamlining language used across lines of business handbooks	**4.10.1 Mental Health Services** ***** Covered Services include diagnostic evaluation, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, and day, intensive outpatient, or partial hospitalization Services. All inpatient, residential, and day, intensive outpatient, or partial hospitalization	**4.10.1 Mental Health Services** ***** Covered Services include diagnostic evaluation, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, ~~and~~ day, intensive outpatient, or partial hospitalization Services. All inpatient, residential, ~~and~~ day, intensive outpatient or partial	No	No	Minor language change to streamline language across handbooks.	

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			treatment Services must be Prior Authorized as specified in section 3.5.*****	hospitalization treatment Services must be Prior Authorized as specified in section 3.5.***** *****				
Chemical Dependency Services	All handbooks	Streamlining language used across lines of business handbooks Personal option references section 4.7 for Prior Authorization	**4.10.3 Chemical Dependency Services** ***** Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, and day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan or their authorizing agent. Prior Authorization is required for all inpatient, residential, and day, intensive outpatient, or partial hospitalization treatment Services, as specified in section 3.5.	**4.10.3 Chemical Dependency Services** ***** Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization, as stated in section 5.4, residential, ~~and~~ day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by us or our authorizing agent. Prior Authorization is required for all inpatient, residential, ~~and~~ day, intensive outpatient~~,~~ or partial hospitalization treatment Services, as specified in section 4.5.			Minor language change to streamline language across handbooks.	
Genetic Testing and Counseling services	All handbooks	Additional language added to call out exclusion of direct-to-consumer testing	**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	**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	No	No	Language added to clarify that direct consumer genetic tests are not covered under the plan per PHP medical policy.	

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			interventions and solutions that are corrective or therapeutic in nature. Genetic testing requires Prior Authorization as shown in section 3.5.	result in medical interventions and solutions that are corrective or therapeutic in nature. Genetic testing requires Prior Authorization, as shown in section 3.5. All Direct-to-Consumer genetic tests are considered investigational and are not covered.				
Inborn Errors of Metabolism	All handbooks	Streamlining language used across lines of business handbooks	**4.12.2 Inborn Errors of Metabolism** The Plan will provide benefits for Covered Services as shown in the Benefit Summary based upon the type of Services received for diagnosing, monitoring and controlling inborn errors of metabolism, including, but not limited to: phenylketonuria (PKU); homocystinuria; citrullinemia; maple syrup disease; and pyruvate dehydrogenase deficiency; that involve amino acid, carbohydrate and fat metabolism for which medically standard methods exist, including quantification of metabolites in blood, urine or spinal fluid, or enzyme or DNA confirmation in tissues. Covered Services include clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. For coverage of medical foods, see section 4.9.1.	**4.12.2 Inborn Errors of Metabolism** The Plan will provide benefits for Covered Services as shown in the Benefit Summary based upon the type of Services received for diagnosing, monitoring and controlling inborn errors of metabolism, including, but not limited to: phenylketonuria (PKU); homocystinuria; citrullinemia; maple syrup disease; and pyruvate dehydrogenase deficiency; that involve amino acid, carbohydrate and fat metabolism for which medically standard methods exist, including quantification of metabolites in blood, urine ~~or~~, spinal fluid, or enzyme or DNA confirmation in tissues. Covered Services include clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. For coverage of medical foods, see section 4.9.1.	No	No	Minor language change to streamline language across handbooks.	
Covered Services	All handbooks	Streamlining language	**4.13.1 Covered Services** *****	**4.13.1 Covered Services** *****	No	No	Minor language change to streamline language across handbooks.	

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		used across lines of business handbooks	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 benefit maximum. (Note: Travel expenses are not covered for donors.) ***** **4.13.2 Benefits for Transplant Facility Services Provided to the Organ Recipient** ***** The transplant procedure and related inpatient services are billed at a Global Fee. The Global Fee can include facility, professional, organ acquisition and inpatient day charges. It does not include pre-transplant and post-transplant services. The Member/recipient is responsible for the Deductible, Coinsurance or Copayment amounts for the Global Fee at the applicable Inpatient Hospital Service benefit.	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 expenses are not covered for donors.) ***** **4.13.2 Benefits for Transplant Facility Services Provided to the Organ Recipient** ***** The transplant procedure and related inpatient services are billed at a Global Fee. The Global Fee can include facility, professional, organ acquisition and inpatient day charges. It does not include pre-transplant and post-transplant services. The Member/recipient is responsible for the Deductible, Coinsurance or Copayment amounts for the Global Fee at the applicable Inpatient Hospital Service benefit.				

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			The Global Fee and the pre-transplant and post-transplant Services apply to the Member's Out-of-Pocket Maximum.	The Global Fee and the pre-transplant and post-transplant Services will apply to the Member's Out-of-Pocket Maximum.				
Using your Prescription Drug Benefit	All handbooks	Streamlining language used across lines of business handbooks	**4.14.3 Prescription Drug Formulary** ***** Not all FDA-approved drugs are added to the formulary. Non-formulary drug requests require a formulary exception, must be FDA-approved, Medically Necessary, and require by law a prescription to dispense. See section 6.1 under Claims Involving Prior Authorization and Formulary Exception. *****	**4.14.3 Prescription Drug Formulary** ***** Not all FDA-approved drugs are ~~added to the formulary~~covered by Providence Health Plan. Non-formulary drug requests require a formulary exception, must be FDA-approved, Medically Necessary, and require by law a prescription to dispense. See section 6.1 under Claims Involving Prior Authorization and Formulary Exception. *****	No	No	Minor language change to streamline language across handbooks.	
Prescription Drugs	All handbooks		**4.14.4 Prescription Drugs** ***** If your brand-name benefit includes a Copayment or Coinsurance, regardless of the reason or Medical Necessity, and you request a brand-name drug, you will be responsible for the difference in cost between the brand-name and generic drug, in addition to the brand-name drug Copayment or Coinsurance indicated in the Benefit Summary. Your total cost, however, will never exceed the actual cost of the drug. The difference in cost between the brand-name and generic drug will not be applied toward your Out-of-Pocket Maximum, and you will continue to be	**4.14.4 Prescription Drugs** ***** If ~~your brand-name benefit includes a Copayment or a Coinsurance, regardless of the reason or Medical Necessity, and~~ you request a brand-name drug, regardless of the reason or Medical Necessity, you will be responsible for the difference in cost between the brand-name and generic drug, in addition to the brand-name drug Copayment or Coinsurance indicated ~~in~~on the Benefit Summary. Your total cost, however, will never exceed the actual cost of the drug. The difference in cost between the brand-name and generic drug will not be	No	Yes – only the additional sentence for OTC contraception 743A.067(2(j)(C) or 743A.067(4)	Removed language and updated text to provide clarity on brand name and generic prescription medication cost difference.	

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			responsible for the difference in cost after your Out-of-Pocket Maximum is met. ***** **N/A** ******	applied toward your Out-of-Pocket Maximum, and you will continue to be responsible for the difference in cost after your Out-of-Pocket Maximum is met. **Affordable Care Act Preventive Drugs** Affordable Care Act (ACA) preventive drugs are medications, including contraceptives, which are listed in our formulary and are covered at no cost when received from Participating Pharmacies as required by the ACA. Over-the-counter ACA preventive drugs received from Participating Pharmacies will not be covered in full under the ACA preventive benefit without a written prescription from your Qualified Practitioner. However, over-the-counter contraceptives do not require a written prescription, pursuant to Oregon state law. *****			---------- Language added to reflect the POA's existing coverage of ACA preventive drugs. The last sentence reflects clarification, as requested by DFR, that no written prescription is required for over-the counter contraceptives, per Oregon state law.	
Prescription Drugs	All handbooks	Modifying language to provide information on who determines the dispensing	**4.14.5 Prescription Drug Quantity** ***** Other dispensing limits may apply to certain medications requiring limited use, as determined by our medical policy. Prior Authorization is required for amounts exceeding any applicable medication dispensing limits.	**4.14.5 Prescription Drug Quantity** ***** Other dispensing limits may apply to certain medications requiring limited use, as determined by our ~~medical policy.~~Oregon Region Pharmacy and Therapeutics Committee. Prior Authorization is required	No	No	Updated language to add information for who determines prescription dispensing limits.	

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		limits for implementation accuracy and pharmacy initiatives		for amounts exceeding any applicable medication dispensing limits.				
Prescription Drug Limitations	All handbooks	Additional language in number 6 indicating the need for medical necessity	**4.14.7 Prescription Drug Limitations** ***** 6. Compound prescription drugs must contain at least one ingredient that is an FDA-approved prescription drug in therapeutic amount and must be purchased at an In-Network Pharmacy. Compounded drugs from bulk powders that are not a component of an FDA-approved drug are not covered. Claims are subject to clinical review for Medical Necessity and are not guaranteed for payment. ***** **4.14.8 Prescription Drug Exclusions** *****	**4.14.7 Prescription Drug Limitations** ***** 6. Compound prescription drugs must contain at least one ingredient that is an FDA-approved prescription drug in ~~a~~ therapeutic amount, must meet our Medical Necessity criteria and must be purchased at an In-Network Pharmacy. Compounded drugs from bulk powders that are not a component of an FDA–approved drug are not covered. Claims are subject to clinical review for Medical Necessity and are not guaranteed for payment. ***** **4.14.8 Prescription Drug Exclusions** *****	No	No	Additional language added to provide to clarity that Prescription drug limitations needs to meet our medical necessity criteria for coverage.	
Prescription Drug Exclusions	All handbooks	Streamlining language used across lines of business handbooks	1. Drugs or medicines delivered, injected or administered for you by a physician, other provider or another trained person;	1. Drugs or medicines delivered, injected~~,~~ or administered ~~for~~to you by a physician~~,~~ or other provider or	No	No	Minor language change to streamline language across handbooks. Added section number for reference for more information on prescription drug exclusions.	

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			2. Amphetamines and amphetamine derivatives except when used in the treatment of narcolepsy or hyperactivity in children and adults; 3. Drugs prescribed that do not relate to the prevention or treatment of a covered illness or injury; 4. Drugs used for the treatment of fertility/infertility; 5. Fluoride, for Members over the age of 10 years old; *****	another trained person (see section 4.3.5); 2. Amphetamines and amphetamine derivatives, except when used in the treatment of narcolepsy or hyperactivity in children and adults; 3. Drugs prescribed that do not relate to the prevention or treatment of a covered illness or injury; 4. Drugs used for the treatment of fertility/infertility; 5. Fluoride, for Members over ~~the age of~~ 10 years ~~old~~of age; *****				
			4.15.2 Chiropractic Care Services Covered Services from chiropractors: • Office visits. • Manipulation of the spine, joints and/or musculoskeletal soft tissue, a re-evaluation, and/or other Services in various combinations. *****	**4.15.2 Chiropractic Care Services** Covered Services from chiropractors: • Office visits. • Chiropractic m~~M~~anipulation of the spine, joints and/or musculoskeletal soft tissue, a re-evaluation, and/or other Services in various combinations. *****			Minor language change to streamline language across handbooks.	
Claims Payment	All handbooks	Language modified to provide clarity to members of Preservice Claims	**6.1 CLAIMS PAYMENT** ***** **Claims Involving Prior Authorization and Formulary Exception (Pre-Service Claims)** • **For services that do not involve urgent medical conditions:** Providence Health Plan will notify	**6.1 CLAIMS PAYMENT** ***** **Claims Involving Prior Authorization and Formulary Exception (Pre-Service Claims)** • **For Prior Authorization of services that do not involve urgent medical conditions:** Providence Health Plan	Yes	Yes - OR state regulation; no federal mandate	**Note:** These new contract changes are applicable only to ASO groups which are required to or choose to comply with State mandates.	

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			your provider or you of its decision within two business days after the Prior Authorization request is received. If additional information is needed to process the request, Providence Health Plan will notify the provider and the provider will have 45 days to submit the additional information. Within two days of receipt of the additional information, Providence Health Plan will complete its review and notify your provider or you of its decision. If the information is not received within 45 days, the request will be denied. • **For services that involve urgent medical conditions:** Providence Health Plan will notify your provider or you of its decision within 72 hours after the Prior Authorization request is received. If Providence Health Plan needs additional information to	will notify your provider or you of its decision within two business days after the Prior Authorization request is received. If additional information is needed to process the request, Providence Health Plan ~~will notify~~ provide written notice to the Member and the provider ~~and the~~ within two business days of receiving the Prior Authorization request. The Member and the provider will have ~~45~~15 days to submit the additional information. Within two business days of receipt of the additional information, Providence Health Plan will complete its review and ~~notify your provider or you~~provide written notice of its decision to the Member and the provider ~~you of its decision~~. If the information is not received within ~~45~~15 days, the request will be denied. • **For Prior Authorization of services that involve urgent medical conditions:** Providence Health Plan will notify your provider or you of its decision within 72 hours after the Prior Authorization request is received. If Providence Health Plan			Additional changes made to prior authorization requirements for Urgent claims, pursuant to 2019 OR SB 249.	

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			complete its review, it will notify the requesting provider or you within 24 hours after the request is received. The requesting provider or you will then have 48 hours to submit the additional information. Providence Health Plan will complete its review and notify the requesting provider or you of its 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 services that involve formulary exceptions:** For standard requests, Providence Health Plan will notify your provider or you of its decision within 72 hours after receipt of the request. For expedited requests, Providence Health Plan will notify your provider or you of its decision within 24 hours after receipt of the request. To qualify for expedited review, the request must be based upon exigent circumstances.	needs additional information to complete its review, it will notify the requesting provider or you within 24 hours after the request is received. The requesting provider or you will then have 48 hours to submit the additional information. Providence Health Plan will complete its review and notify the requesting provider or you of its 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 ~~services that involve~~ formulary exceptions:** For standard requests, Providence Health Plan will notify your provider or you of its decision within 72 hours after receipt of the request. For expedited requests, Providence Health Plan will notify your provider or you of its decision within 24 hours after receipt of the request. To qualify for expedited review, the request must be based upon exigent circumstances.				
Submission of Claims	All handbooks	Streamlining language	**6.1.1 Timely Submission of Claims**	**6.1.1 Timely Submission of Claims**	No	No	Minor language change to streamline language across handbooks.	

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		used across lines of business handbooks Correct the ORS number stated due to it being renumbered	The Plan will make no payments for claims received more than 365 days after the date of Service. Exceptions may be made if Providence Health Plan receives documentation that you lacked legal capacity during that period. Payment of claims submitted by the Oregon state Medicaid agency or a prepaid managed care health services organization described in ORS 414.651 (i.e., a Coordinated Care Organization) will be made in accordance with ORS 743.847, which establishes payment requirements for claims submitted by the Oregon state Medicaid agency. *****	We will make no payments for claims received more than 365 days after the date of Service. Exceptions ~~may~~will be made if we receive documentation that you lacked legal capacity during that period. Payment of claims submitted by the Oregon state Medicaid agency or a prepaid managed care health services organization described in ORS 414.651 (i.e., a Coordinated Care Organization) will be made in accordance with ORS 743~~.847~~470, which establishes payment requirements for claims submitted by the Oregon state Medicaid agency. *****			Updated ORS number to follow its newly issued number.	
Coordination with Medicare	All handbooks	Streamlining language used across lines of business handbooks	**6.2.7 Coordination with Medicare** ***** When the Employer Group's size is 20 individuals or more, Medicare will be considered the secondary payer. *****	**6.2.7 Coordination with Medicare** ***** 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. *****	No	No	Minor language change to streamline language across handbooks.	
Informal Problem Resolution	All handbooks	Streamlining language used across lines of business handbooks	**7.1 INFORMAL PROBLEM RESOLUTION** All employees of Providence Health Plan share responsibility for assuring Member satisfaction. If you have a problem or concern about your coverage, including benefits or Services by Network Providers or payment for Services by Out-of-Network Providers, please ask for	**7.1 INFORMAL PROBLEM RESOLUTION** All employees of Providence Health Plan share responsibility for assuring Member satisfaction. If you have a problem or concern about your coverage, including benefits or Services by In-Network Providers or payment for Services by Out-of-Network Providers,	No	No	Minor language change to streamline language across handbooks.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Grandfathered plans, as filed with the State of Oregon DFR for plan year 2020. 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, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0119 documents)	New Language & Provisions (in new 0120 documents)	Benefit change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
		Changing wording from consent to authorization to clearly reflect how an authorized representative is selected	Providence Health Plan's help. Customer Service is available to provide information and assistance. You may call or meet with Providence Health Plan at the phone number and address listed on your Member ID Card. If you have special needs, such as a hearing impairment, Providence Health Plan will make efforts to accommodate your requirements. Please contact Customer Service for help with whatever special needs you may have. **7.2 MEMBER GRIEVANCE AND APPEAL***** ***** **Authorized Representative** An individual who by law or by the consent of a Member may act on behalf of the Member. *****	please ask for our help. Your Customer Service representative is available to provide information and assistance. You may call us or meet with us at the phone number and address listed on your Member ID Card. If you have special needs, such as a hearing impairment, we will make efforts to accommodate your requirements. Please contact us so we may help you with whatever special needs you may have. **7.2 MEMBER GRIEVANCE AND APPEAL***** ***** **Authorized Representative** An individual who by law or by the ~~consent~~authorization of a Member may act on behalf of the Member. *****				
Internal Grievance or Appeal	All handbooks	Streamlining language used across lines of business handbooks	**7.2.2 Internal Grievance or Appeal** You must file your internal Grievance or Appeal within 180 days of the date on the notice of the initial Adverse Benefit Determination, or that initial determination will become final. Please advise Providence	**7.2.2 Internal Grievance or Appeal** You must file your internal Grievance or Appeal within 180 days of the date on our notice of the initial Adverse Benefit Determination, or that initial determination will become final. Please advise us of any	No	No	Minor language change to streamline language across handbooks.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Grandfathered plans, as filed with the State of Oregon DFR for plan year 2020. 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, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0119 documents)	New Language & Provisions (in new 0120 documents)	Benefit change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
			Health Plan of any additional information that you want considered in the review process. If you are seeing an Out-of-Network Provider, you should contact that provider's office and arrange for the necessary records to be forwarded to Providence Health Plan for the review process. Your Grievance or Appeal will be reviewed by Providence Health Plan staff not involved in the initial determination. You may present your case in writing. Once a final determination is made you will be sent a written explanation of the decision. *****	additional information that you want considered in the review process. If you are seeing an Out-of-Network Provider, you should contact ~~that~~ the provider's office and arrange for the necessary records to be forwarded to ~~us~~Providence Health Plan for the review process. Your Grievance or Appeal will be reviewed by Providence Health Plan staff not involved in the initial determination. You may present your case in writing. Once a final determination is made you will be sent a written explanation of the decision. *****				
Voluntary Level Second Appeal	All handbooks	Removing section 7.2.3 on voluntary internal second level appeals	**7.2.3 Voluntary Second Level Internal Appeal** If you are not satisfied with the decision of the internal Appeal and your Appeal is of an Adverse Benefit Determination that involves (a) medical judgment (including, but not limited to, Plan determinations that involve medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or experimental/investigational treatment) or (b) rescission of coverage (whether or not the rescission has an effect on any particular benefit at that time) , you may request a voluntary second level internal Appeal. If your case is eligible, it will be reviewed by	~~**7.2.3 Voluntary Second Level Internal Appeal**~~ ~~**If you are not satisfied with the decision of the internal Appeal and your Appeal is of an Adverse Benefit Determination that 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 a prescription drug formulary, you may request a voluntary second level internal Appeal.**~~ ~~If your case is eligible, it will be reviewed by Providence~~	No	No	Effective 1/01/2020, PHP has made a business decision to streamline our internal appeals process by eliminating the voluntary second level of internal appeal, which is not required by federal law. We believe this will make our administration of internal appeals more efficient and better serve our Members.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Grandfathered plans, as filed with the State of Oregon DFR for plan year 2020. 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, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0119 documents)	New Language & Provisions (in new 0120 documents)	Benefit change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
			Providence Health Plan's Grievance Committee. The members of the Grievance Committee are individuals not involved in the initial decision to uphold an Appeal. You must submit your written request for the voluntary second level internal Appeal within 60 days of the date on the internal Grievance or Appeal decision notice or that initial decision will become final. The Grievance Committee will review all documentation presented by you and send a written explanation of its decision within 30 days of receiving your request for the voluntary second level internal Appeal.	~~Health Plan's Grievance Committee. The members of the Grievance Committee are individuals not involved in the initial decision to uphold an Appeal. You must submit your written request for the voluntary second level internal Appeal within 60 days of the date on the internal Grievance or Appeal decision notice, or that initial decision will become final. The Grievance Committee will review all documentation presented by you and send a written explanation of its decision within 30 days of receiving your request for the voluntary second level internal Appeal.~~				
External Review	All handbooks	Renumber section 7.2.4 and removing mention of voluntary second level internal Appeal decision due to previous section being removed Streamlining language used across	**7.2.4 External Review** If you are not satisfied with the internal Grievance or Appeal decision or the decision of the voluntary second level internal Appeal and your Appeal is of an Adverse Benefit Determination that 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) whether an exception to the Plan's prescription drug formulary should be granted, you may request an external review by an IRO. Your request must be made in	**7.2.34 External Review** If you are not satisfied with the internal Grievance or Appeal decision ~~or the decision of the voluntary second level internal Appeal~~ and your Appeal is of an Adverse Benefit Determination that 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) whether an exception to the Plan's prescription drug formulary should be granted, you may request an external review by an IRO. Your request must be	No	No	Section reference updates to reflect removal of Voluntary Second Level Internal Appeals.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Grandfathered plans, as filed with the State of Oregon DFR for plan year 2020. 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, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0119 documents)	New Language & Provisions (in new 0120 documents)	Benefit change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
		lines of business handbooks	writing within 180 days of receipt of the internal Grievance or Appeal decision or voluntary second level internal Appeal decision, or that internal decision will become final. If you agree, Providence Health Plan may waive the requirement that you exhaust the internal review process before beginning the External Review process. Providence Health Plan will notify the Oregon Insurance Division within two business days of receiving your request for external review, at which point an IRO will be assigned to the case by the Oregon Insurance Division and Providence Health Plan will forward complete documentation regarding the case to the IRO.	made in writing within 180 days of receipt of the internal Grievance or Appeal decision ~~or voluntary second level internal Appeal decision~~, or that internal decision will become final. If you agree, Providence Health Plan may waive the requirement that you exhaust the internal review process before beginning the External Review process. Providence Health Plan will notify the Oregon Insurance Division within two business days of receiving your request for external review, at which point an IRO will be assigned to the case by the Oregon Insurance Division and Providence Health Plan will forward complete documentation regarding the case to the IRO.				
Eligibility and enrollment	All handbooks	Streamlining language used across lines of business handbooks/	**8. ELIGIBILITY AND ENROLLMENT** This section outlines who is eligible for coverage, and how and when to enroll yourself and your Eligible Family Dependents. No benefits shall be available to anyone not enrolled on this Plan. You and your Employer must provide us with evidence of eligibility as requested.	**8. ELIGIBILITY AND ENROLLMENT** This section outlines who is eligible for coverage, and how and when to enroll yourself and your Eligible Family Dependents. No benefits shall be available to anyone not enrolled ~~on~~under this Plan. You and your Employer must provide us with evidence of eligibility as requested.	No	No	Minor language change to streamline language across handbooks.	
Cobra Premiums	All handbooks	Streamlining language used across lines of	**10.1.7 COBRA Premiums** If you are eligible for COBRA continuation coverage, you do not have to show that you are insurable (that you do not have any	**10.1.7 COBRA Premiums** If you are eligible for COBRA continuation coverage, you do not have to show that you are insurable (that you do not have any	No	No	Minor language change to streamline language across handbooks.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Grandfathered plans, as filed with the State of Oregon DFR for plan year 2020. 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, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0119 documents)	New Language & Provisions (in new 0120 documents)	Benefit change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
		business handbooks	serious health conditions). However, you must pay the full premium for your continuation coverage, including the portion of the premium Clackamas County was previously paying. After you elect COBRA, you will have 45 days from the date of election to pay the first premium. You must pay premium back to the point you would otherwise have lost coverage under this Plan. After that, you must pay the premium for each month as of the first of the month, and in all events within 30 days. If you fail to pay your monthly premium, you will be notified that your coverage is being terminated.	serious health conditions). However, you must pay the full premium for your continuation coverage, including the portion of the premium Clackamas County was previously paying. After you elect COBRA, you will have 45 days from the date of election to pay the first premium. You must pay the premium back to the point you would otherwise have lost coverage under this Plan. After that, you must pay the premium for each month as of the first of the month, and in all events within 30 days. If you fail to pay your monthly premium, you will be notified that your coverage is being terminated.				
Definitions	All handbooks Addition of "Ambulatory Surgery Center" definition applies to Personal Option only	Streamlining language used across lines of business handbooks Also including minor grammatical error corrections	**15. DEFINITIONS** ***** **Approved Clinical Trial** Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment or cancer or other disease or condition and is one of the following: **Benefit Summary** Benefit Summary means the documents with that title that are part of this Plan and	**15. DEFINITIONS** ***** **Approved Clinical Trial** Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment or cancer or other life-threatening disease or condition and is one of the following: ***** **Benefit Summary** Benefit Summary means the documents with that title that are part of ~~this~~your Plan	No	No	Minor language change to streamline language across handbooks.	

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Grandfathered plans, as filed with the State of Oregon DFR for plan year 2020. 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, as well as between different ASO plan types.

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			summarize the benefit provisions under this Plan. ***** **Copayment** Copayment means the dollar amount that you are responsible to pay to a health care provider when you receive certain Covered Services, as shown in the Benefit Summary. ***** **Director** Director means the director of the Oregon Division of Financial Regulation. ***** **Experimental/Investigational** Experimental/Investigational means Services that are determined by us not to be Medically Necessary or accepted medical practice in the Service Area, including Services performed for research purposes. In determining whether Services are Experimental/Investigational, we will consider whether the Services are in general use in the medical community in the U.S.; whether the Services are under continued scientific testing and research; whether the Services show a demonstrable benefit for a	and summarize the benefit provisions under ~~this~~your Plan. ***** **Copayment** Copayment means the dollar amount that you are responsible ~~to pay~~for paying to a health care provider when you receive certain Covered Services, as shown in the Benefit Summary. ***** ~~**Director**~~ ~~Director means the director of the Oregon Division of Financial Regulation.~~ ***** **Experimental/Investigational** Experimental/Investigational means Services ~~that are determined by us not to be Medically Necessary or accepted~~for which current prevailing, evidence-based, peer-reviewed medical ~~practice in the~~ literature does not demonstrate the safety and effectiveness of the Service ~~Area, including Services performed for research purposes.~~for treating or diagnosing the condition or illness for which its use is proposed. In determining whether Services are Experimental/Investigational~~, we will~~			Removal of Director definition as it is no longer necessary to reference in the handbook. Updated language for Experimental/Investigational definition to reflect current PHP medical policy.	

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Topic	Affected Material	Description	Current Language & Provisions (from existing 0119 documents)	New Language & Provisions (in new 0120 documents)	Benefit change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
			particular illness or disease; whether they are proven to be safe and efficacious; and whether they are approved for use by appropriate governmental agencies. We determine on a case-by-case basis whether the requested Services will result in greater benefits than other generally available Services, and will not approve such a request if the Service poses a significant risk to the health and safety of the Member. We will retain documentation of the criteria used to define a Service deemed to be Experimental/Investigational and will make this available for review upon request. *****	~~consider whether the Services are in general use in the medical community in~~ the ~~U.S.;~~Plan considers a variety of criteria, which include, but are not limited to, whether the Services are ~~under continued scientific testing and research; whether the Services~~ : • Approved by the appropriate governmental regulatory body; • Subject to review and approval of an institutional review board (IRB) or are currently offered through an approved clinical trial; • Offered through an accredited and proficient provider in the United States; • Reviewed and supported by national professional medical societies; • Address the condition, injury, or complaint of the Member and show a demonstrable benefit for a particular illness or disease; • ~~whether they are~~ Proven to be safe and efficacious; and ~~whether they are approved for use by appropriate governmental agencies. We determine on a case-by-case basis whether the requested Services will result in~~				

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Grandfathered plans, as filed with the State of Oregon DFR for plan year 2020. 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, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0119 documents)	New Language & Provisions (in new 0120 documents)	Benefit change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
				~~greater benefits than other generally available Services, and will not approve such a request if the Service poses~~ • Pose a significant risk to the health and safety of the Member. The experimental/investigational status of a Service may be determined on a case-by-case basis. We will retain documentation of the criteria used to define a Service ~~deemed to be~~as Experimental/Investigational and will make this available for review upon request. ***** **Hearing Assistance Technology** See section 5.9.18. *****			_____ Added Hearing Assistance Technology (HAT) definition added to reflect the referenced defined term in the handbook.	

KAISER PERMANENTE

2020 *Group Agreement* and *Evidence of Coverage* Summary of Changes and Clarifications for Oregon Large Employer Groups

This is a summary of changes and clarifications that we have made to your *Group Agreement*. The *Group Agreement* includes the *Evidence of Coverage* (*EOC*), "Benefit Summary," and any applicable rider and endorsement documents. This summary does not include minor changes and clarifications we are making to improve the readability and accuracy of the *Group Agreement*. These changes and clarifications do not include changes that may occur throughout the remainder of the year as a result of federal or state mandates.

Other Group-specific or product-specific plan design changes (including changes to Copayment or Coinsurance amounts) may apply, such as moving to standard benefits. Refer to the Rate Proposal and/or the Summary of Plan Changes document for information about these types of changes.

To the extent that this summary of changes and clarifications conflicts with, modifies, or supplements the information contained in your *Group Agreement*, the information contained in the *Group Agreement* shall supersede what is set forth below. Unless another date is listed, the changes in this document are effective when your Group renews in 2020. The products named below are offered and underwritten by Kaiser Foundation Health Plan of the Northwest.

Changes and clarifications that apply to Traditional, Deductible, High Deductible, Added Choice®, and PPO Plus medical plans

Changes to Senior Advantage plans are explained at the end of this summary.

Benefit changes

- The "Referrals to Participating Providers and Participating Facilities" section of the Traditional, Deductible, and High Deductible Health Plan *EOC* has been modified. Ophthalmology has been removed from the list of departments that do not require a referral for outpatient Services. A referral will now be required to schedule an appointment for ophthalmology Services.

Benefit clarifications

- The "What You Pay" section of the *EOC* has been modified to align with changes made to the "Benefit Summary" describing all Deductible accumulation types in terms of a self-only Deductible, an individual Family Member Deductible, and a Family Deductible. The edits provide clarification to Members by distinguishing the difference between self-only and an individual in a Family. Aggregate and embedded accumulation types are now discerned by the amounts listed on the "Benefit Summary" for each of the categories.
- The "What You Pay" section of the *EOC* has been modified to align with changes made to the "Benefit Summary" describing all Out-of-Pocket accumulation types in terms of a self-only Out-of-Pocket Maximum, an individual Family Member Out-of-Pocket Maximum, and a Family Out-of-Pocket Maximum to provide clarification to Members by distinguishing the difference between self-only and an individual in a Family. Aggregate and embedded accumulation types are now discerned by the amounts listed on the "Benefit Summary" for each of these categories.
- The "Emergency, Post-Stabilization and Urgent Care" in the *EOC* has been modified to reflect a change in terminology on the "Benefit Summary." Emergency Services has been changed to emergency

department visit to more accurately describe when the emergency department visit Copayment or Coinsurance applies.

- The "Emergency Services" section of the *EOC* has been modified to specify that Emergency Services may be received anywhere in the world as long as the Services would have been covered under the "Benefits" section if received by a Participating Provider or at a Participating Facility.
- The "Preventive Care Services" section of the *EOC* has been modified to clarify that Services to diagnose current or ongoing signs or symptoms are not considered preventive and may be subject to applicable cost shares.
- The "Hearing Aid Services for Dependents" section of the *EOC* has been modified to clarify coverage requirements per the amendment of ORS 743A.141 in the 2018 Oregon House Bill (HB) 4104. A new "Hearing Aid Services for Dependents Limitations" section has been added to describe the limited coverage of replacement ear molds and hearing aid batteries as stated in HB 4104. These benefits were covered in 2019, language has been added to the 2020 contract documents for Member clarity. An exclusion has also been removed from the "Hearing Aid Services for Dependents Exclusions."
- The "Limited Outpatient Prescription Drugs and Supplies" section of the *EOC* has been modified for better alignment with the "Outpatient Prescription Drug Rider" and to provide clarity regarding how to get covered drugs and supplies.
- The "Limited Outpatient Prescription Drugs and Supplies" section of the *EOC* has been modified to clarify that lancets and injection aids are covered under the "Outpatient Durable Medical Equipment (DME)" section.
- The "Outpatient Durable Medical Equipment (DME)" section of the *EOC* has been modified to reflect that lancets and injection aids are covered under the DME benefit.
- The "Reconstructive Surgery Services" section of the Traditional, Deductible and High Deductible Health Plan *EOCs* has been modified to specify that Services are covered when prescribed by a Participating Physician and are subject to Utilization Review. The word significant has been removed in this section for consistency across products. Services are covered based upon Utilization Review.
- The "Custodial Services" exclusion in the "Exclusions and Limitations" section of the *EOC* has been changed to "Custodial Care." The exclusion has also been modified to align across lines of business for Member clarity.
- The phrase "not subject to Deductible" has been removed from several rows of the "Benefit Summary" for contract integrity and continuity. Our contract convention is to specify when benefits are subject to the Deductible and to not reference the Deductible when it does not apply. The "What You Pay" section of the *EOC* notes that the "Benefit Summary" indicates which Services are subject to the Deductible.
- The "Deductible" section of the "Benefit Summary" has been modified to describe all accumulation types in terms of a self-only Deductible, an individual Family Member Deductible, and a Family Deductible. Aggregate accumulation is represented when the individual Family Member Deductible amount equals the Family Deductible amount. Embedded accumulation is represented when the self-only Deductible amount equals the individual Family Member Deductible amount.
- The "Out-of-Pocket Maximum" section of the "Benefit Summary" has been modified to describe all accumulation types in terms of a self-only Out-of-Pocket Maximum, an individual Family Member Out-of-Pocket Maximum, and a Family Out-of-Pocket Maximum. Aggregate accumulation is represented when the individual Family Member Out-of-Pocket Maximum amount equals the Family Out-of-Pocket

Maximum amount. Embedded accumulation is represented when the self-only Out-of-Pocket Maximum amount equals the individual Family Member Out-of-Pocket Maximum amount.

- The Emergency Services row of the "Benefit Summary" has been changed to emergency department visit to more accurately reflect when the emergency department visit Copayment or Coinsurance applies.
- The "Hearing Aid Services for Dependents" section of the "Benefit Summary" has been modified to clarify coverage requirements per the amendment of ORS 743A.141 in the 2018 Oregon House Bill (HB) 4104. Language has been added to clarify that hearing aids are limited to one per ear every 36 months.
- The "Palliative and comfort care" row in the "Benefit Summary" has been removed to avoid confusion. These Services are included under hospice Services without a separate cost share.
- A row for tobacco use cessation drugs has been added to the "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" to align with covered Services listed in the *EOC*.
- The "Lancets and injection aids" row in the "Benefit Summary has been moved from the "Limited Outpatient Prescription Drugs and Supplies" section to the "Outpatient Durable Medical Equipment" section for accuracy as the DME cost share applies to these items.

Administrative changes or clarifications

- The "Definitions" section of the *EOC* has been modified. The definition of Dependent Limiting Age has been modified for consistency of terminology with the "Benefit Summary."
- The defined term "Medical Directory" has been changed throughout the Traditional, Deductible, and High Deductible Health Plan *EOCs* to "Medical Facility Directory" to accurately reflect the directory name as it appears on **kp.org**. The definition has also been modified for accuracy.
- The "Definitions" section of the *EOC* has been modified. Language indicating that a Member may contact Member Services has been removed from definitions where present, as it is not a defining characteristic and to reduce redundancy.
- The definition of "Dependent Limiting Age" has been modified for clarity.
- The "Dependents" section in the "Who is Eligible" section has been updated for clarity regarding the eligibility of a person who is under the student Dependent Limiting Age. This applies to Groups that choose to cover Dependents over the age 26 if they are full-time registered students.
- The Advice Nurses section has been modified for accuracy to reflect that an Advice Nurse may be reached by contacting the Member Services number during normal business hours, as well as, evenings, weekends, and holidays rather than contacting a specific medical office. The list of Member Services numbers has been removed to ensure accuracy and consistency. It is listed on the *EOC* cover, as well as, in the "Getting Assistance" section.
- The "Your Primary Care Participating Provider" section of the Traditional, Deductible, and High Deductible Health Plan *EOC* has been modified for accuracy, to reflect that changes to a primary care Participating Provider take effect immediately.
- Language in the "Appointments for Routine Services" section has been re-ordered for accuracy and alignment across products.
- The Member Services phone number has been removed from the body of the *EOC* (except in the "Grievances, Claims, Appeals, and External Review" section) to ensure accuracy and consistency. It is listed on the *EOC* cover, as well as, in the "Getting Assistance" section.

- The "Limited Outpatient Prescription Drugs and Supplies" section of the *EOC* has been modified. Language has been added to explain that while a Member may obtain a first fill of a prescription drug at any participating pharmacy, all refills must be obtained at a pharmacy owned and operated by Kaiser Permanente (including our mail-order pharmacy), or at another participating pharmacy we designate for covered refills.
- The "Help with Your Claim and/or Appeal" section of the *EOC* has been modified. The name of the Consumer Advocacy Unit has been updated to the Consumer Advocacy Section, a fax number has been added, the email address has been revised, and the URL has been updated for accuracy.
- In the "Grievances, Claims, Appeals, and External Review" section of the *EOC*, the Member Relations fax number has changed to accommodate a new digital fax process.
- Language in the "Termination Due to Loss of Eligibility" section of the *EOC* has been revised for clarity.
- The "Nondiscrimination" section of the *EOC* has been modified to confirm that we do not discriminate based on a Member's marital status.
- The "Limited Outpatient Prescription Drugs and Supplies" section of the Traditional, Deductible, and High Deductible Health Plan "Benefit Summary" has been modified for consistency within the contract. The word "formulary" has been removed from the row for contraceptive drugs, as all prescription drugs received from a Participating Pharmacy are formulary.
- A "Grandfathered Health Plan Coverage" section has been added to the "Miscellaneous Provisions" section of the *Group Agreement*, indicating that a Group must inform Company if coverage identified as a "grandfathered health plan" in the *EOC* does not meet (or no longer meets) the requirements for grandfathered status.

Additional changes and clarifications that apply to Added Choice® medical plans only

Benefit changes

- The "Referrals to Select Providers and Select Facilities" section of *EOC* has been modified. Ophthalmology has been removed from the list of departments that do not require a referral for outpatient Services. A referral will now be required to schedule an appointment for ophthalmology Services.

Benefit clarifications

- The "Reconstructive Surgery Services" section of the *EOC* has been modified to align with other sections within the *EOC*. Language indicating that Services are covered when prescribed by a Select, PPO, or Non-Participating Provider has been moved to the beginning of the section. Additionally, language has been added to specify that Services are subject to Utilization Review. The word significant has been removed in this section for consistency across products. Services are covered based upon Utilization Review.
- The Chiropractic Services Received Without a Referral" exclusion in the "Exclusions and Limitations" section of the *EOC* has been retitled "Chiropractic Services" for alignment with other products and other exclusions within the section.
- The "Custodial Care" exclusion in the "Exclusions and Limitations" section of the *EOC* has been modified to align across lines of business and for Member clarity.

- The "Optometric Vision Therapy and Orthoptics (Eye Exercises)" exclusion in the "Exclusions and Limitations" section of the *EOC* has been modified for clarity and moved so that it appears in alphabetical order. Language has been added explaining that Services related to optometric vision therapy and orthoptics (eye exercises) are excluded.
- A "Hospitalization on Your Effective Date" section has been added to the *EOC* for alignment across products.
- A sentence has been added to the second paragraph of the "Benefit Summary" to clarify that all applicable visit limits are combined across all tiers, unless otherwise indicated in the *EOC*. Language has been removed from the left column of the "Benefit Summary" table indicating "all tiers combined."
- A row for "certain preventive medications" has been added to the "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" to align with covered Services listed in the *EOC*.
- The "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" has been modified for better alignment with the "Outpatient Prescription Drug Rider" to more accurately reflect that these drugs may be obtained from Select Pharmacies or Medimpact Pharmacies.

Administrative changes or clarifications

- The "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" has been modified for accuracy. The word "formulary" has been removed from the row for contraceptive drugs. In addition to Select Pharmacies and Facilities, this section represents limited prescription drugs and supplies received from MedImpact Pharmacies, which are not subject to the formulary.
- The defined term "Added Choice Medical Directory" has been changed throughout the *EOC* to "Medical Facilities Directory" to accurately reflect the directory name as it appears on **kp.org**. The definition has also been modified for accuracy.
- The "Your Primary Care Select Provider" section of the *EOC* has been modified for accuracy to reflect that changes to a primary care Select Provider take effect immediately.

Additional changes and clarifications that apply to PPO Plus medical plans only

Benefit clarifications

- The "Reconstructive Surgery Services" section of the *EOC* has been modified to align with other sections within the *EOC*. Language has been moved and modified to specify that Services are subject to Utilization Review by Company. The word significant has been removed in this section for consistency across products. Services are covered based upon Utilization Review.
- The "Custodial Care" exclusion in the "Exclusions and Limitations" section of the *EOC* has been modified to align across lines of business and for Member clarity.
- A sentence has been added to the "Benefit Summary" to clarify that all applicable visit limits are combined across both tiers, unless otherwise indicated in the *EOC*. Language has been removed from the left column of the "Benefit Summary" table indicating "both tiers combined."
- The "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" has been modified for better alignment with the "Outpatient Prescription Drug Rider" to more accurately reflect that these drugs may be obtained from Medimpact or Kaiser Permanente Pharmacies.

Administrative changes or clarifications

- The "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" has been modified for accuracy. The word "formulary" has been removed from the row for contraceptive drugs. In addition to Kaiser Permanente Pharmacies, this section represents limited prescription drugs and supplies received from MedImpact Pharmacies, which are not subject to the formulary.

Changes and clarifications that apply to medical benefit riders

Benefit clarifications

- The "Alternative Care Services Rider" has been modified for better clarity around coverage for specific treatment modalities. References to the *EOC* "Exclusions and Limitations" have been moved to the subsections for each modality. Additionally, the modality references in the provider definitions have been removed.
- The "Outpatient Prescription Drug Rider" has been modified. All references to the medical directory have been updated to "Medical Facility Directory" to reflect the revised definition in the *EOC*.
- The "Outpatient Prescription Drug Rider" has been modified. A "Prior Authorization Exception Process" subsection has been added to the "About Our Drug Formulary" section to align across lines of business and ensure consistency of administration.
- The rows for tobacco use cessation drugs and contraceptives have been removed from the "Outpatient Prescription Drug Rider Benefit Summary" to reduce redundancy. These items are included in the "Limited Outpatient Prescription Drugs and Supplies" section of the *EOC*.
- References to the Deductible and Prescription Drug Deductible have been removed from the "Copayments and Coinsurance for Covered Drugs and Supplies" and "Day Supply Limit" sections of the "Outpatient Prescription Drug Rider" contract integrity and administrative consistency. The "Deductible" section of the *EOC* describes how the Deductible is applied. The "Outpatient Prescription Drug Rider Benefit Summary" indicates which Services are subject to the Deductible.
- The "About Our Drug Formulary" section in the "Outpatient Prescription Drug Rider" has been modified for accuracy and Member clarity.
- The phrase "not subject to Deductible" has been removed from several rows of the "Outpatient Prescription Drug Rider Benefit Summary" for contract integrity and continuity. Our contract convention is to specify when benefits are subject to the Deductible and to not reference the Deductible when it does not apply.
- The "Pediatric Vision Hardware and Optical Services Rider Benefit Summary" (including the rider for the enhanced benefit) has been modified for clarity. The "You Pay" cells for comprehensive eye exams and low vision evaluations have been updated to show the Member cost share rather than pointing to the primary care visit cost share in the *EOC* "Benefit Summary."

Administrative changes or clarifications

- The "Covered Drugs and Supplies" section of the "Outpatient Prescription Drug Rider" has been modified. Language has been added to explain that while a Member may obtain a first fill of a prescription drug at any participating pharmacy, all refills must be obtained at a pharmacy owned and operated by Kaiser Permanente (including our mail-order pharmacy), or at another participating pharmacy we designate for covered refills.

KAISER PERMANENTE

Changes and clarifications that apply to dental plans

Benefit clarifications

- To align with current administration, language regarding diagnosis and evaluation was removed from the Oral Surgery Services, Periodontic Services, and Endodontic Services sections and added to the Oral Exam row in the benefit summary to clarify that all exams, including diagnosis and evaluation, are subject to the Preventive and Diagnostic Services cost share.
- Benefits within the *EOC* and Benefit Summary have been alphabetized when appropriate to do so.
- The "Exclusions and Limitations" section has been modified to align across lines of business, where appropriate, ensure consistency of administration, and aid in Member clarity. This synchronization did not result in any benefit changes.
- To better align with state regulations, several limitations in the "Limitations" section have been modified by changing the language from "covered" to "limited to."

Administrative changes or clarifications

- The definition of *Dental Provider Directory* has been modified for accuracy and a new definition for *Dental Facility Directory* has been added. References throughout the *EOC* have been updated with the corresponding directory name.
- In the "Definitions" section and throughout the *EOC*, the dental PPO Third Party Administrator (TPA) name has changed from Scion Dental, Inc. to SKYGEN USA, LLC, ("SKYGEN").
- The definition of "Dependent Limiting Age" in the "Definitions" section of the *EOC* has been modified for clarity.
- The "Dependents" section under "Who is Eligible" in the *EOC* has been updated to clarify the bullet regarding the eligibility of a person who is under the student Dependent Limiting Age. This section applies to Groups that choose to cover Dependents over the age 26 if they are full-time registered students.
- The "Adding New Dependents to an Existing Account" section of the *EOC* has been modified. Language has been added to clarify that an enrollment application is required to add new dependents if additional premium is required to add the dependent and that the application requirement is waived if additional premium is not required.
- A "Referrals" section has been added to all nonPPO plans for clarity and transparency.
- The "Prior Authorization" section in PPO plans has been modified to reflect that providers can now request Prior Authorization on a Member's behalf electronically. The language about requesting prior authorization by fax has also been removed, since there is no longer a fax number on the back of Members' ID cards.
- The address in the "Post-Service Claims - Services Already Received" section has been updated to reflect that nonPPO dental claim forms should be sent to our local dental claims' office in Portland, Oregon.
- The Member Services phone number has been removed throughout the *EOC* when referring Members to contact Member Services (except in the "Grievances, Claims, and Appeals" section) to ensure accuracy and consistency. It is listed on the *EOC* cover, as well as, in the "Getting Assistance" section.

- The "Help with Your Claim and/or Appeal" section has been modified. The name of the Consumer Advocacy Unit has been updated to the Consumer Advocacy Section, a fax number has been added, the email address has been revised, and the URL has been updated for accuracy.
- In the "Grievances, Claims, and Appeals" section, the Member Relations fax number has changed to accommodate a new digital fax process.
- Language in the "Termination Due to Loss of Eligibility" section has been revised for clarity.
- The language in the "Termination for Cause" section has been revised to reflect that Members may only be terminated for fraud and misrepresentation. It has also been updated for consistency.
- The "Nondiscrimination" section has been modified to confirm that we do not discriminate based on a Member's marital status.

Changes and clarifications that apply to dental benefit riders

Benefit clarifications

- The "Dental Implant Services Rider" has been modified for clarity.
    - The first bullet in the "Dental Implant Benefit" section has been moved out of alphabetical order to the end of the list since it is a secondary alternative to the other benefits listed.
    - The "Repair of a Dental Implant" limitation has been modified to include a clarifying sentence that provides for repairs when postoperative complications or failure of a Dental Implant happens through no fault of the Member.

Changes and clarifications that apply to all Senior Advantage plans

Benefit changes and clarifications

- The following changes have been made to the Medical Benefits Chart:
    - Opioid treatment program services have been added to the Chart. Covered services include FDA-approved opioid treatment medications, substance use counseling, individual and group therapy, and toxicology testing.
    - Outpatient hospital observation services are now in a separate row of the Chart. Previously, these services were addressed under the "Emergency care" and "Outpatient hospital services" rows. Language has been added to explain to members what observation services are and the conditions for coverage.
    - More detailed information about covered telehealth services has been added to the "Physician/practitioner services, including doctor's office visits" section of the Chart. This section now describes numerous services available through telehealth when clinically appropriate.
- In Chapter 3, Section 2.2 of the *EOC*, the list of services that do not require referral has changed. Members will need a PCP referral for services from obstetrics/gynecology, occupational health and social services.
- Information has been added to Chapter 3, Section 3.2 of the *EOC* to clarify the circumstances under which we cover worldwide urgent care services outside the United States.
- For Medicare Part D plans, Chapter 5, Section 5.2 of the *EOC* has been modified to explain that we will offer a temporary supply of a non-formulary drug if the member experiences a level of care change. We

will cover up to a one-month supply of the Part D drug during level of care transitions even if the drug is not on our Drug List (formulary).

- For Medicare Part D plans, Chapter 5, Section 6.2 of the *EOC* has been edited to clarify what happens when there are changes to the Drug List (formulary); if and when coverage changes for a drug the member is taking; and how the member is notified. The Senior Advantage 2020 Annual Notice of Change (*ANOC*) that is sent to Senior Advantage members provides additional detail explaining what happens if a drug the member is taking is changed or removed from the 2020 Drug List, and what a member can do, such as working with their provider to find a different drug that we cover or to ask for a formulary exception.

Administrative changes and clarifications

- The eligibility requirements list in Chapter 1, Section 2.1 of the *EOC*, has been modified to remove a restriction. We allow enrollment in our group Senior Advantage plan when a person's Medicare coverage is either primary or secondary to the group plan.
- Information about coverage decisions, appeals and complaints in Chapter 9 of the *EOC* for plans with Medicare Part D, and Chapter 7 of the *EOC* for plans without Medicare Part D, has been updated to explain when we or the IRO must respond if the request for benefits determination is for a Medicare Part B drug.

Clackamas County (POA)
Oregon ASO Dental Plan Changes
Renewing January 1, 2020

The following is a summary of the significant changes that will be made to the Delta Dental ASO Agreement and member handbook when your group renews in 2020. The summary is provided for your convenience and shall not be binding upon the parties. The language in the ASO Agreement and member handbook is controlling in all cases. Minor changes, including grammatical, cosmetic or formatting changes or moving sections around for ease of use are not included in this summary.

FEDERAL REGULATORY CHANGES			
Reference	**Former Benefit**	**Change/Rationale/Exceptions**	**Claims Impact***
ACA	Delta Dental will monitor for any changes to the ACA.	To be determined	TBD

STATE REGULATORY CHANGES			
Reference	**Former Benefit**	**Change/Rationale/Exceptions**	**Claims Impact***
SB 421	When a third party is responsible for an injury, the Plan may recover claims costs.	Changes to the subrogation process may affect the Plan's ability to recover claims costs.	TBD

BENEFIT CHANGES						
Accepted		**Reference**	**Former Benefit**	**New Benefit**	**Explanation**	**Claims Impact***
Yes	**No**					
☐	☒	**Benefits and Limitations** Consultation	Consultation was covered regardless of whether the related services were covered.	Consultation in conjunction with non-covered services is denied.	Align consultation with covered services.	Negligible

BENEFIT CHANGES						
Accepted		**Reference**	**Former Benefit**	**New Benefit**	**Explanation**	**Claims Impact***
Yes	**No**					
☐	☒	**Benefits and Limitations** Periodic or comprehensive exams	Problem focused detailed extensive oral evaluations were covered twice per year as a limited or re-evaluation exam.	Problem focused, detailed, extensive oral evaluations are covered as a periodic / comprehensive exam.	Problem focused, detailed extensive oral evaluations are a comprehensive service.	Negligible
☐	☒	**Benefits and Limitations** Space maintainer	The Plan allowed once per space. Space maintainers for primary anterior teeth or missing permanent teeth or for members are not covered.	The Plan allows once per space per quadrant as a lifetime benefit. Space maintainers for primary anterior teeth or missing permanent teeth or for members age 14 or over are not covered.	Change based on evidence based practice.	Negligible
☒	☐	**Benefits and Limitations** Interim caries arresting medicament	Not covered.	Interim caries arresting medicament application is covered twice per tooth per benefit year. -- **YES** **NO -**Restorations within 3 months of interim caries arresting medicaments are not covered. - NO	A new service for the treatment of tooth decay.	+0.07%
☐	☒	**Benefits and Limitations** Restorative services - Basic	The Plan covers post and core in addition to crown.	The Plan denies post and core in addition to a crown unless more than half of the coronal tooth structure remains.	Change based on evidence based practice.	Negligible

BENEFIT CHANGES						
Accepted		**Reference**	**Former Benefit**	**New Benefit**	**Explanation**	**Claims Impact***
Yes	**No**					
☐	☒	**Benefits and Limitations** Repair to crown, inlay and onlay	The Plan reviewed for necessity if the repair was made to a crown, inlay or onlay within 24 months by a different dentist.	Repair made to a crown, inlay or onlay within 24 months is denied.	Repair is included in the charge for the original care.	Negligible
☐	☒	**Benefits and Limitations** Endodontic services	Retrograde fillings were covered.	Retrograde fillings by the same dentists within a 2-year period of the initial retrograde filling is not covered.	Retreatment is included in the charge for the original care.	Negligible
☒	☐	**Benefits and Limitations** Oral surgical services	Osseous surgery was covered subject to consultant review.	Osseous surgery is limited to 2 quadrants per date of service.	Based on evidence based dentistry.	Negligible
☐	☒	**Benefits and Limitations** Oral surgical services	Bone replacement graft was covered subject to consultant review.	Bone replacement grafts are limited to once per single tooth or multiple teeth within a quadrant in any 3-year period.	Based on evidence based dentistry.	Negligible
☒	☐	**Benefits and Limitations** Oral surgical services	Post-operative care for oral and maxillofacial surgery was covered subject to consultant review within 30 days of the surgical service.	A separate charge for post-operative care done within 30 days following oral surgery is not covered.	Post-operative care within 30 days is included in the surgery charge.	-0.25%
☐	☒	**Benefits and Limitations** Prosthodontic services	Re-cement or re-bond implant/abutment supported crown or fixed partial denture was covered.	Re-cement or re-bond implant/abutment supported crown or fixed partial denture is limited to once in any 12-month period.	Additional re-cement or re-bond is likely due to underlying issues with the implant or abutment.	Negligible

ADMINISTRATIVE CHANGES		
Reference	**Change/Rationale/Exceptions**	**Details**
Overall	Minor changes for improved readability.	This includes separating 1 sentence into 2 and replacing some words with simpler synonyms.
Benefits and Limitations Diagnostic & Preventive	Added language stating limited exam and re-evaluation are covered up to 2 exams per plan year.	Clarifying the existing frequency for these benefits.
Benefits and Limitations Diagnostic & Preventive	Added language to explain that adult prophylaxis is only allowed for age 12 and over.	Members under 12 receive child prophylaxis.
Benefits and Limitations Endodontic services	Add language that pulpotomy in conjunction with a root canal is not covered.	The pulpotomy is included in the charge for the root canal.
Benefits and Limitations Periodontal services	Added language to clarify periodontal surgical procedures by the same dentist within a 3-year period of the initial surgery is not covered.	Additional services should be included in the cost of the initial procedure.
Benefits and Limitations Surgical Stent **Exclusions** Maxillofacial prosthetics	Added language to clarify surgical stent is covered in conjunction with covered surgical procedures. All other maxillofacial prosthetics are not covered.	Delta Dental processing policy.
Benefits and Limitations Implants	Added language to describe scaling and debridement of an implant is limited to once per implant in a 2-year period.	Language added to clarify the current process.
Benefits and Limitations Other services Orthodontia	Added language to explain that orthodontia is covered when an in-person clinical exam of the patient is performed to establish the need for orthodontics.	Clarify that self-administered orthodontics are not covered.
Benefits and Limitations Other services Teledentistry	Teledentistry is not covered as a separate benefit.	Teledentistry is included in the fees for overall patient management.
Benefits and Limitations Other services Translation	Translation or sign language service is not covered as a separate benefit.	Translation or sign language service are included in the fees for overall patient management.

ADMINISTRATIVE CHANGES		
Reference	**Change/Rationale/Exceptions**	**Details**
Exclusions Behavior management	Added language to exclude behavior management.	Additional charges for extra time or services to manage behavioral issues are not covered.
Exclusions Copy of records	Copying a patient's records is not covered.	Dental office administrative process is not covered.
Exclusions Coping	Coping, a thin covering of the coronal portion of a tooth, is not covered.	Specialized procedures are not covered.
Exclusion Tobacco counseling	Added exclusion except if members are qualified under the Health through Oral Wellness program.	Members with enhanced benefits based on a high risk of oral cancer are eligible for tobacco cessation counseling.
Exclusions Treatment of closed fractures	Added exclusion for treatment of closed fractures.	Clarification of the current administration.
Enrollment Loss of Eligibility by Dependent	Added language clarifying that dependent coverage based legal guardianship ends when the subscriber is no longer the legal guardian.	Grandchildren are eligible when the subscriber is the legal guardian. When the guardian relationship legally ends earlier than age 26, the grandchild's coverage also ends.

ASO AGREEMENT CHANGES
None

*Based on Delta Dental book of business.

Additional changes may be required at any time as a result of new federal rules or regulations; changes to existing ACA rules or regulations or State law. Delta Dental will provide written notice of any additional changes including any modification to administrative fees, and will administer such changes accordingly.

Services are provided by Oregon Dental Service doing business as Delta Dental Plan of Oregon (Delta Dental). Delta Dental is part of the Moda organization.

Signature POA Agreement - Signature Pending _____ **Date** _____