



OREGON MEMBER HANDBOOK

OREGON EDUCATORS BENEFIT BOARD

open option plan

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1. INTRODUCTION

Thank you for choosing Providence Health Plan. We look forward to meeting your healthcare needs. Following is a brief outline of several key aspects of this Member Handbook.

- Important terms appear throughout this Member Handbook as capitalized text and their definitions can be found in section 17.
- Throughout this Member Handbook, the terms “you” and “your” mean any Member enrolled in and entitled to Covered Services under this Open Option Plan. The terms “we”, “us”, and “our” mean Providence Health Plan.
- This Member Handbook includes this document and any Summary of Benefits, Endorsements and amendments that accompany this document.
- Coverage under this Open Option Plan is provided through:
 - Our network of Participating Providers located in Oregon and southwest Washington,
 - Our national network of Participating Providers, **plus**
 - Non-Participating Providers, as specified in the Endorsement for Out-of-Plan Benefits.
- With an Open Option plan, you will usually have lower out-of-pocket expenses when you receive Covered Services from Participating Providers. You may, however, receive most Covered Services from Non-Participating Providers, but that option will result in higher out-of-pocket expenses for most Covered Services. Please see section 4 and the Summary of Benefits for additional information.
- The following Services are covered **only** under the In-Plan benefits, as specified on the Summary of Benefits:
 - All E-visit Services (see section 5.1.2)
 - All outpatient Prescription Drug Services (see section 5.10)
 - All Human Organ/Tissue Transplants (see section 6.1)
- All Members are encouraged to choose a Personal Physician/Provider who will provide preventive and primary care Services and coordinate other care in a convenient and cost-effective manner.
- A printed directory of Participating Providers is available to all Members. On-line access to our Oregon Participating Providers and our national network of Participating Providers is available at our Internet site at: www.providence.org/healthplans. If you do not have Internet access, and would like a printed listing of Participating Providers, please contact us directly and we will send you a printed listing of the Participating Providers located in the area(s) you request.
- Coverage under this Open Option Plan is available twenty-four (24) hours a day, seven (7) days a week and during periods of domestic or foreign travel.
- **Certain Covered Services require an approved Prior Authorization, as specified in section 4.7.**
- Coverage **limitations** and **exclusions** apply to certain Services, as stated in sections 4, 5 and 6 and any Summary of Benefits.

2. WELCOME TO PROVIDENCE HEALTH PLAN

Providence Health Plan is an exclusive provider organization (EPO) plan offered by Providence Health & Services. The organization consists of a network of hospitals, clinics, urgent care centers, physicians, other health care providers and health plans. Our goal is to help improve the health status of individuals in the communities in which we serve.

2.1 YOUR OPEN OPTION PLAN

Your Open Option Plan allows you to receive all covered services from Participating Providers through what is called your “In-Plan” benefit. You also have the option to receive most Covered Services from Non-Participating Providers through what is called your “Out-of-Plan” benefit. Generally, your out-of-pocket costs will be less when you receive Covered Services from Participating Providers. Also, Participating Providers will work with us to Prior Authorize treatment. If you receive Covered Services from Non-Participating Providers, it is your responsibility to make sure the Services listed in section 4.7 are Prior Authorized by us before treatment is rendered.

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 Participating Provider.

If you are unsure about a physician/provider’s, hospital’s or other facility’s participation with Providence Health Plan, visit our Online Participating Provider Directory for Open Option Plan Members at www.providence.org/healthplans before you make an appointment. You can also call your Customer Service team to get information about a provider’s participation with Providence Health Plan.

Whenever you visit a Participating Provider:

- Bring your Providence Health Plan member identification card with you.
- If your office visit is subject to a Copayment, you will need to make that Copayment at the time of your visit.
- If your office visit is subject to a Coinsurance (a percentage of the amount billed for Services), you will most likely not be able to pay for what you owe at the time of your visit. Your provider’s office will send you a bill for what you owe later. Some providers, however, may ask you to pay for an estimate of what you may owe at the time you receive services and bill or credit you for the balance later.

2.2 YOUR MEMBER HANDBOOK

This Member Handbook contains important information about the health insurance we offer to the Oregon Educators Benefits Board (OEBB). It is important to read this Member Handbook carefully as it explains your Providence Health Plan benefits and your responsibilities as a Providence Health Plan Member. If you don’t understand a term that is used, you may find it in Definitions, section 17. To help you find specific information, an index is located in the back of this book. If you need additional help understanding anything in this Member Handbook, please call your Customer Service team at 503-574-7500 or 1-800-878-4445. See “Your Customer Service Team,” section 2.3, for additional information on how to reach your Customer Service team.

Your Member Handbook is not complete without your:

- **Open Option Summary of Benefits** and any other supplemental Summary of Benefits documents. These materials are available on our Internet site at www.providence.org/healthplans when you are register for a myProvidence account as explained in section 2.4. These materials list in detail your Copayments and Coinsurance for Covered Services and also give you important information for any supplemental benefits you have (like prescription drugs or vision).
- **Online Participating Provider Directory.** Participating Providers are listed on our Internet site at www.providence.org/healthplans. You will need this directory to access Covered Services from Participating Providers. If you do not have Internet access, please call your Customer Service team to obtain a paper directory.

Occasionally, you may need more detailed information for a specific problem or situation. If this occurs, contact OEBB, your district or your Customer Service team.

2.3 YOUR CUSTOMER SERVICE TEAM

We want you to understand how to use your Providence Health Plan benefits. We also want you to be satisfied with your health plan. Your Customer Service team is here to help you understand your benefits and resolve any problems you may have. Your Customer Service team will handle:

- Specific benefit or claim questions.
- Address and name changes.
- Questions or concerns about adding or dropping a dependent.
- Enrollment issues.
- Questions or concerns about your health care or service.

How to contact your Customer Service team

Here is all you need to do to get in touch with your Customer Service team:

- **Have your Providence Health Plan member identification card ready when you call. Your card lists your member number.**
- **If you live in:**
 - **Portland-metro area: Call 503-574-7500.**
 - **All other areas: Call 1-800-878-4445.**
 - **For TTY (Telecommunication services for the hearing impaired), please call 503-574-8702 or 1-888-244-6642.**
- **Follow the easy-to-use menu selections to be connected to your Customer Service team or to access your claims and benefit information via our voice-recognition phone system.**

Your Customer Service team is available from 8 a.m. to 5 p.m., Monday through Friday, excluding holidays. In addition, our automated voice-recognition phone system is available during non-business hours for you to access claims and benefit information, seven days a week.

2.4 REGISTERING FOR A myPROVIDENCE ACCOUNT

Your Member materials, including your Summary of Benefits and Member Handbook are available on our Internet site when you register for a myProvidence account at www.providence.org/healthplans. When you register for a myProvidence account, you can view your personal health plan information, view claims history and payment, order a replacement member identification card and access other health and wellness tools and services.

2.5 YOUR MEMBER IDENTIFICATION CARD

Each Member of Providence Health Plan receives a member identification card. Your member identification card lists information about your health plan coverage, including:

- Your Member number and group number
- Your particular health plan
- Important phone numbers

Supplemental Benefits are any benefits purchased by OEBB in addition to your Open Option medical health care coverage, such as the Prescription Drug benefit. Your member identification card will not list all of your Supplemental Benefits. If your plan includes coverage for supplemental benefits, your member materials will include a Summary of Benefits for each Supplemental Benefit.

When scheduling an appointment or receiving health services, identify yourself as a Providence Health Plan Member, present your member identification card and pay your Copayment or Coinsurance.

Please keep your health plan member card with you and use it when you:

- Have appointments with your health care provider.
- Call for Mental Health/Chemical Dependency Customer Service.
- Call or write your Customer Service team.
- Call Providence RN, our medical advice line.
- Visit your pharmacy for prescriptions.
- Receive Urgent or Emergency Care Services.

2.6 PROVIDENCE RN

Providence RN — 503-574-6520; 1-800-700-0481

Providence RN is a free medical advice line for Providence Health Plan members. You may call Providence RN at 503-574-6520 (Portland-metro area) or 1-800-700-0481 (all other areas) with your health-related questions and speak to a registered nurse, 24 hours a day, seven days a week.

For TTY (telephone device for the hearing impaired), call 1-800-735-2900 (Oregon Relay for TTY).

Please have your member identification card available when you call.

Members often call when they have sick children at home, or when they have questions about how to treat flu, colds or backaches. After a brief recorded message, a registered nurse will come on the line to help. The nurse can answer many of the questions you may have, or let you know whether you should seek a doctor's care.

Important note for residents of California: In accordance with California state law, the services of Providence RN are not available to California state residents.

2.7 **WELLNESS BENEFITS**

Providence Resource Line — 503-574-6595; 1-800-562-8964

Providence Resource Line is your connection to information and services on classes, self-help materials, stop-smoking services, and for referrals to Providence Health Plan Participating Providers and to Providence Health & Services programs and services. Services and health-education vary by geographic service area.

Health Education

No matter what your health-related interest, you will find a wide variety of classes to help ensure your success. We can assist you in learning to eat right and manage your weight, prepare for childbirth, learn how to quit smoking and much more. If you have diabetes, health education classes also are available. See section 5.2.9, for further information. Providence Health Plan members receive discounts on health education classes supporting smoking cessation, childbirth education and weight management. Your costs, services and the health education classes available may vary by geographic service area. For more information on classes available in your area, call the Providence Resource Line at 503-574-6595 or 1-800-562-8964 or visit www.providence.org/classes.

Wellness information on our Internet site — www.providence.org/healthplans

Visit us online at www.providence.org/healthplans for medical information, class information, information on extra values and discounts and a wide array of other information listed with your good health in mind. You also may set up your own myProvidence account to gain access to your specific personal health plan information. See *Registering for a myProvidence account*, section 2.4, for more details.

LifeBalance — 503-234-1375 or 1-888-754-LIFE www.LifeBalanceProgram.com

This program, exclusively for members of Providence Health Plan, provides discounts on a variety of recreational, cultural and wellness activities throughout Oregon and southwest Washington. You will save on professional instruction, rentals, fitness club memberships, musical events, and much more. Members also have access to discounted member events, such as white-water rafting, ski trips, theater nights, and sporting events.

Learn more by visiting the LifeBalance Internet site at www.LifeBalanceProgram.com or call LifeBalance at 503-234-1375 or 1-888-754-LIFE for a printed directory of discount providers. Please have your Providence Health Plan member identification card ready when you request LifeBalance discounts.

3. 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 under this Open Option Plan. You and OEGB must provide us with evidence of eligibility as requested.

There will be an Annual Group Enrollment Period each Plan Year. The Effective Date of Coverage for new Members who enroll during the Annual Group Enrollment Period is the beginning of the Plan Year for which they enroll.

See your OEGB handbook for further details or contact OEGB or the Subscriber's District directly.

3.1 EMPLOYEE ELIGIBILITY AND ENROLLMENT

3.1.1 Employee Eligibility Date

An employee is eligible for coverage when the employee meets the definition of an Eligible Employee, as defined in section 17.

3.1.2 Employee Effective Date

The Effective Date of Coverage will follow the completion of any Eligibility Waiting Period as defined by the Eligible Employee's District.

3.1.3 Employee Enrollment

To obtain coverage, an Eligible Employee must enroll within the time period specified by OEGB and the Eligible Employee's District. The next earliest time the Eligible Employee may enroll is the next occurring Annual Group Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependents may qualify to enroll during a special enrollment period. See section 3.3 for additional information.

3.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

3.2.1 Eligibility Date

Each Eligible Family Dependent is eligible for coverage on:

1. The date specified by the Eligible Employee's District;
2. For any Eligible Family Dependents acquired on the date of the Subscriber's marriage, on the first day of the month following the date of marriage;
3. The date of birth of the biological child of the Subscriber or Subscriber's spouse;
4. The date a child is placed with the Subscriber or the Subscriber's spouse for the purpose of adoption by the Subscriber or the Subscriber's spouse;
5. The date the Subscriber or the Subscriber's spouse is required to provide health coverage to a child under a qualified medical child support court or administrative order; or
6. The date on which legal guardianship status begins.

3.2.2 Additional Requirements for Eligible Family Dependent Coverage

1. An Eligible Employee may cover her or his Eligible Family Dependents ONLY if she or he is also covered, and requests enrollment as specified below.
2. If a child becomes an Eligible Employee the child is no longer an Eligible Family Dependent and must make application as an Eligible Employee.

3.2.3 Eligible Family Dependent Enrollment

You must enroll Eligible Family Dependents by submitting an enrollment application to the Eligible Employee's District or through the MYOEBS system. To obtain coverage, the Eligible Family Dependent must enroll within 31 days after becoming eligible as indicated in section 3.2.1 (see section 3.2.4 regarding newborn and adopted children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Annual Group Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 3.3.

3.2.4 Newborn Eligibility and Enrollment

A newborn or adopted child of a Member who meets the definition of an Eligible Family Dependent is covered for up to 31 days from the date of birth or placement for the purpose of adoption. You must submit enrollment within 60 days from the date of birth for coverage to continue beyond the 31-day period. Enrollment after this time period may be accomplished as outlined in sections 3.2.3 and 3.3.

3.3 SPECIAL ENROLLMENT PERIODS

See your OEBS handbook for further details or contact OEBS or your District directly.

If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your spouse) during a previous enrollment period (as stated in sections 3.2.3 and 3.2.4), you may be eligible to enroll yourself or the Eligible Family Dependent during a "special enrollment period" provided that you request enrollment within thirty (30) days of the qualifying event and meet the applicable requirements stated in this section.

In instances where an Eligible Family Dependent of a Subscriber qualifies for a "special enrollment period," the Subscriber and the Eligible Family Dependent may:

- Enroll in the coverage currently elected by the Subscriber; or
- Enroll in any benefit option for which the Subscriber and Eligible Family Dependent is eligible.

3.3.1 Loss of Other Coverage

If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your spouse) because of other health insurance coverage and you lose that other coverage, we will provide a "special enrollment period" for you and/or your Eligible Family Dependent if:

- a) The person was covered under a group health plan or had other health coverage (includes benefits consisting of medical care under any hospital or medical services policy or certificate, or HMO) at the time coverage under this policy was first offered to the person; and

- b) The person stated in writing that coverage under such group health plan or health insurance coverage was the reason for declining enrollment; but only if we required such a statement and provided the person with notice of such requirement (and the consequences of such requirement) at such time; and
- c) Such coverage:
- was under a COBRA Continuation provision and the coverage under such a provision was exhausted; except when the person failed to pay timely premium; or if coverage terminated for cause, (such as making a fraudulent claim or an intentional misrepresentation of a material fact); or
 - was not under a COBRA Continuation provision and the coverage was terminated as a result of:
 1. The individual's loss of eligibility for the coverage; including as a result of legal separation, divorce, death; termination of employment, or a reduction in the number of hours of employment; except when the person failed to pay timely premium or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact); or
 2. The individual's loss of eligibility for coverage under Medicaid, Medicare, TRICARE, Indian Health Service or domestic or foreign publicly sponsored or subsidized health plan; including but not limited to the Oregon Health Plan (OHP); and the individual applies for coverage under this Open Option Plan within sixty-three (63) days of the termination of such coverage; or
 3. The termination of contributions toward such coverage by the current or former Employer; or
 4. The individual incurring a claim that exceeds the lifetime limit on all benefits; and the individual applies for coverage under this Open Option Plan within thirty (30) days after the claim is denied.

Effective Date: Coverage under this Open Option Plan will take effect on the date specified by your School District.

3.3.2 New Dependents

If you were eligible to enroll as a Subscriber under this Open Option Plan, but did not enroll during a previous enrollment period, and a person becomes your Eligible Family Dependent through marriage, birth, adoption or placement for adoption; we will provide a "special enrollment period" during which you and your Eligible Family Dependent(s) may enroll under this Open Option Plan.

The "special enrollment period" shall be a period of thirty (30) days and begins on the later of:

- the date Dependent coverage is made available under this Open Option Plan; or
- the date of the marriage, birth, or adoption or placement for adoption.

Effective Date:

- on the first day of the month following the date of marriage; or
- in the case of a Dependent's birth, on the date of such birth; or
- in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption; or
- in the case of legal guardianship of a Dependent, the date such legal guardianship status begins.

3.3.3 Court Orders

If you were eligible to enroll as a Subscriber under this Open Option Plan, but did not enroll during a previous enrollment period, and a court orders you to provide coverage for a spouse or minor child under your Health Benefit Plan, we will provide a “special enrollment period” for you and the spouse or minor child you are ordered to provide coverage for if you request enrollment within thirty (30) days after the issuance of the court order.

Effective Date: The date specified in the court order. If there is no date specified on the order, coverage will be effective the first of the month following the date the order is issued.

3.4 MEMBERS AFFECTED BY A REPLACEMENT OF GROUP COVERAGE

- If you are confined in a Hospital on your Effective Date of Coverage and OEBC replaces a prior Oregon-based group policy or contract with this Open Option Plan with no lapse in coverage, benefit availability for Covered Services under this Open Option Plan will be affected. Specifically, you will continue to receive benefits for Covered Services from the prior group policy until you are discharged from the Hospital or until the limits of the prior group policy have been reached, whichever is earlier.

3.5 LEAVE OF ABSENCE AND LAYOFFS

A Subscriber on an District-approved leave of absence, for any reason including illness or a temporary shutdown, may continue to be covered under this Open Option Plan as though actively at work, at the District’s option, for up to twelve (12) weeks. Absences extending beyond this time period will be subject to sections 11, 12 and 13.

A Subscriber who has been laid off and rehired will be eligible for coverage as determined by the Subscriber’s District.

For the Subscriber, a leave of absence granted under the federal Family and Medical Leave Act (FMLA), the Uniformed Services Employment and Reemployment Rights Act (USERRA), or similar state laws is administered in accordance with those Acts and this Open Option Plan.

4. HOW TO USE YOUR PLAN

Our goal is helping you maintain your health by promoting wellness and preventive care. We encourage you to work closely with one provider, your Personal Physician/Provider, who can provide most of your care, suggest specialist care and arrange for Hospital care or diagnostic testing.

This section describes how to use this plan and how benefits are applied. The level of benefits for Covered Services is shown in the Summary of Benefits and described in sections 5 and 6 of this Member Handbook.

Important Note: See section 1 and your Summary of Benefits regarding Covered Services obtained from Participating Providers and Non-Participating Providers.

4.1 PARTICIPATING PROVIDERS

Providence Health Plan has contractual arrangements with certain Qualified Practitioners, Hospitals and facilities located throughout Oregon and southwest Washington. Our agreements with these “Participating Providers” enable you to receive quality health care for a reasonable cost.

For In-Plan benefits to be covered, you must receive Services from Participating Providers. It is your responsibility to verify whether or not a Qualified Practitioner, Hospitals or other facility is participating with us even if you have been directed or referred for care by a Participating Provider.

Nationwide Network of Participating Providers

Providence Health Plan also has contractual arrangements with certain Qualified Practitioners, Hospitals and facilities nationwide. These arrangements allow you to receive Services using your In-Plan benefits, even when you are outside of Oregon and southwest Washington.

Choosing a Participating Provider

To choose a Participating Provider, or to verify if a provider is participating, go to our Online Participating Provider Directory at www.providence.org/healthplans and select as your plan type “OEBB.” See our instructions for finding a physician, provider or facility on the opening page of this Member Handbook for additional details. If you do not have access to our Internet site, please call your Customer Service team to request Participating Provider information.

Advantages to Using a Participating Provider

- Your Participating Provider will work with Providence Health Plan to arrange for any prior authorization requirements that may be necessary for certain covered services. For more information on Prior Authorization, see section 4.7.
- In most cases when you use Participating Providers, higher benefit levels will apply and your out-of-pocket expenses will be reduced; and
- You will have a wide variety of high quality Participating Providers to help you with your health care needs.

So remember, it is to your advantage to meet your health care needs by using a Participating Provider, including a Participating Personal Physician/Provider, whenever possible.

Indian Health Services Providers

Native American Members may also access Covered Services from Indian Health Services (IHS) facilities at no greater cost than if the Services were accessed from a Participating Provider. For a list of IHS facilities, please either visit the IHS Internet site at <http://www.ihs.gov>, or contact the regional IHS office at:

Portland Area Indian Health Service
1220 SW Third Ave #476
Portland, OR 97204
Telephone: 503-326-4123
Fax: 503-326-7280

4.2 THE ROLE OF A PERSONAL PHYSICIAN/PROVIDER

The focus of this plan, and every plan we offer, is on helping you maintain your health by encouraging wellness and preventive care. We also believe wellness and overall health is enhanced by working closely with one physician or provider – your Personal Physician /Provider. A Personal Physician/Provider can provide most of your routine and preventive care and can advise you regarding appropriate use of specialty care. Because a Personal Physician/Provider knows your health care history and has your medical records, he or she can coordinate your health care in a convenient and cost-effective manner. A list of Participating Personal Physician/Providers can be found in the Participating Provider Directory.

Please see your Summary of Benefits for coverage of Services from a Personal Physician/Provider.

Your Personal Physician/Provider

Your Personal Physician/Provider is a physician who specializes in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; a certified nurse midwife; or a physician assistant, when providing services under the supervision of a physician; who agrees to be responsible for the continuing medical care by serving as case manager.

Adult female Members may choose a physician specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women’s health care as their personal physician/provider.

Personal Physicians/Providers provide preventive care and health screening, medical management of many chronic conditions, allergy shots, treatment of some breaks and sprains, and care for many major illnesses and nearly all minor illnesses and conditions. Many Personal Physicians/Providers offer maternity care and minor outpatient surgery as well.

When you select a Participating Personal Physician/Provider, your out-of-pocket costs for office visits will generally be lower. You can, however, select a Non-Participating Personal Physician/Provider. When you do this, your out-of-pocket costs will generally be higher. The choice is up to you.

IMPORTANT NOTE: Participating Personal Physicians/Providers have a special agreement with us to serve as a case manager for your care. This means not all of our Participating Providers with the specialties listed above are Participating Personal Physician/Providers. Please see our Online Participating Provider Directory for a listing of designated Participating Personal Physicians/Providers or call your Customer Service team to obtain a paper copy.

Established Patients with Personal Physician/Providers

If you and your Dependents already see a provider who meets the definition of a Personal Physician/Provider, please check the provider directory to see if your provider is a Participating Personal Physician/Provider for Providence Health Plan. If your provider is participating with us, let his or her office know you are now a Providence Health Plan Member.

Selecting a New Personal Physician/Providers

If you don't have a regular personal physician/provider or your provider is not a Participating Provider with Providence Health Plan, we recommend you choose one from our Online Participating Provider Directory for each covered Dependent. Call the provider's office to make sure he or she is accepting new patients.

Soon after you select your Personal Physician/Provider, it is a good idea to have your previous physician or provider transfer your medical records to your new Personal Physician/Provider. The first time you make an appointment with your Personal Physician/Provider let him or her know you are now a Providence Health Plan Member.

On your first visit make a list of questions or information you would like to discuss with your new Personal Physician/Provider, including the following:

- What are the office hours?
- How can I get medical advice after hours?
- What do I do in an emergency?

Let your Personal Physician/Provider know if you are under a specialist's care. Also, inform your Personal Physician/Provider of any ongoing prescription medications you are currently taking.

Selecting a New Personal Physician/Providers

You are encouraged to establish an ongoing relationship with your Personal Physician/Provider. We understand, however, how important it is for you and your Dependents to feel confident in your choice of providers. If you decide to change your Personal Physician/Provider, please remember to have your medical records transferred to your new Personal Physician/Provider.

Personal Physician/Provider Office Visits

We recommend you see your Personal Physician/Provider for all routine care and call your Personal Physician/Provider first for Urgent or specialty care. If you need medical care when your Personal Physician/Provider is not available, the Personal Physician/Provider on call may treat you and/or recommend that you see another provider who specializes in treatment for your condition.

4.3 SERVICES PROVIDED BY NON-PARTICIPATING PROVIDERS

As an Open Option Plan member, you may choose to receive Covered Services from Non-Participating Providers using your Out-of-Plan benefit.

Benefits for Covered Services by a Non-Participating Provider will be provided as shown in the Summary of Benefits. See section 4.7 Prior Authorization requirements.

Generally, when you receive Services from Non-Participating Providers, your Copayments and Coinsurance will be higher than when you see Participating Providers.

When you use Non-Participating Providers, we provide benefits for Medically Necessary Covered Services only when the Services are received from Qualified Practitioners and Qualified Facilities, and only when the provider is practicing within the scope of his or her license. See section 17 for the definition of Qualified Practitioner and Qualified Facility.

IMPORTANT NOTE: While Providence Health Plan will provide reimbursement for Covered Services received from Non-Participating Providers, some **Services are only covered under your In-Plan benefit:**

- E-visits (see section 5.1.2)
- All outpatient Prescription Drug Services (see section 5.10)
- All Human Organ/Tissue Transplants (see section 6.1)

Payment for Non-Participating Physician/Provider Services (UCR)

After you meet your Out-of-Plan Deductible, if any, we will provide payment to Non-Participating Providers for Covered Services according to Usual, Customary and Reasonable charges (UCR). UCR charges do not include sales taxes, handling fees and similar surcharges; such taxes, fees and surcharges are not covered expenses. Charges which exceed UCR are the Member's responsibility and are not applied to the Out-Of-Pocket Maximum.

Should you choose to receive Services from a Non-Participating Provider you will be responsible for costs that are not covered or allowed by your Out-of-Plan benefits as shown in the following example.

<u>Item</u>	<u>Provider's Status</u>	
	<u>Participating</u>	<u>Non-Participating</u>
Provider's standard charges	\$100	\$100
Allowable charges under this Open Option Plan	\$80 (contracted)	\$80 (UCR)
Plan benefits (for this example only)	\$64 (if 80% benefit)	\$56 (if 70% benefit)
Balance you owe	\$16	\$24
Additional amount that the provider may bill to you	\$-0-	\$20 (\$100 minus \$80)
Total amount you would pay	\$16	\$44 (\$24 plus \$20)

4.4 NOTICE OF PROVIDER TERMINATION

When a Participating Provider whose contract of participation with us terminates, we will notify those Members who we know are under the care of the terminated provider within ten (10) days of the termination date or of our knowledge of the termination date.

4.5 EMERGENCY CARE SERVICES

Benefits for an Emergency Medical Condition are provided both in Oregon and worldwide. If an emergency situation should occur, you should take immediate action and seek prompt medical care. You should call 911, or the emergency number listed in the local telephone directory or go to the nearest Hospital emergency department. For further description of Emergency Care Services, see section 5.7.

4.6 URGENT/IMMEDIATE CARE SERVICES

Benefits for Urgent/Immediate Care are provided in Oregon and worldwide. If you should have a need for Urgent/Immediate Care Services, seek prompt medical care from an Urgent/Immediate Care facility or other Qualified Practitioner. (For further description of Urgent/Immediate Care Services, see section 5.8.)

4.7 COVERED SERVICES THAT REQUIRE PRIOR AUTHORIZATION

While Prior Authorization is a requirement for coverage of certain Services under this Open Option 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 his/her provider and is separate from the Prior Authorization requirements of this Member Handbook. Further, Prior Authorization is not a guarantee of benefit payment under this Open Option Plan and a Prior Authorization determination does not supersede other specific provisions of this Open Option Plan regarding coverage, limitations, exclusions and Medically Necessary Services.

When your Covered Services are to be received from a Participating Provider, he or she will contact US to obtain Prior Authorization. **However, if the Services are to be received from a Non-Participating Provider, it is Member's responsibility to contact us to obtain Prior Authorization.** Your Non-Participating Provider may agree to contact us on your behalf.

Covered Services that require Prior Authorization are:

- All inpatient admissions to a Hospital (not including emergency room care), Skilled Nursing Facility or a rehabilitation facility, all emergency hospitalizations (we need to be notified within forty-eight (48) hours, or as soon as reasonably possible) and all Hospital admissions for maternity/delivery Services;
- All outpatient surgical procedures;
- All inpatient, residential and day or partial hospitalization treatment Services for Mental Health and Chemical Dependency conditions, as provided in sections 5.4 and 5.5;
- All human organ/tissue transplant related Services, as provided in 6.1;
- All Restoration of Head/Facial Structures; Limited Dental Services as provided in section 6.2;
- All PET, CT, CTA, MRI and MRA imaging and Nuclear Cardiac Study Services as provided in section 5.9.4;
- All home health care Services as provided in section 5.9.5;

4. HOW TO USE YOUR PLAN

- All hospice Services as provided in section 5.9.6;
- All medical supplies/devices, prosthetic devices and Durable Medical Equipment in excess of \$500 as provided in section 5.9.8;
- All outpatient hospitalization and anesthesia for dental Services as provided in section 6.2.2; and
- All outpatient cardiac rehabilitation Services as provided in section 5.6.

We will provide a Prior Authorization form upon oral or written request. If you need information on how to obtain Prior Authorization, please call your Customer Service representative at the number listed on your Member ID Card.

If an Emergency Medical Condition exists which prevents you from obtaining Prior Authorization, we must be notified within forty-eight (48) hours following the onset of treatment, or as soon as reasonably possible, to continue coverage of these Services.

4.7.1 Failure to Obtain Prior Authorization

If you do not obtain a Prior Authorization for Services received from a Non-Participating Provider, as specified in section 4.7, a fifty percent (50%) Coinsurance penalty, not to exceed \$2,500 for each Covered Service occurrence, will be applied.

This penalty does **NOT** apply to the Out-of-Plan Deductible, if any, and the Out-of-Pocket Maximum shown in the Summary of Benefits.

4.8 MEDICAL COST MANAGEMENT

Coverage under this Open Option Plan is subject to the medical cost management protocols established by us to ensure the quality and cost effectiveness of Covered Services. Such protocols may include Prior Authorization, concurrent review, case management and disease management.

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 may share your information with your Participating Providers and Hospitals to help them provide medical care to you. For example, if you are in the Hospital, we may provide Hospital personnel involved in your treatment access to any medical records sent to us by your Participating Providers.

We may use or share your information with others to help manage your health care. For example, we might talk to your Participating Provider to suggest a disease management or wellness program that could improve your health.

We reserve the right to deny payment for Services that are not Medically Necessary in accordance with the criteria maintained by us. When more than one (1) medically appropriate alternative is available, we will approve the least costly alternative.

We reserve the right to make substitutions for Covered Services. Substituted Services must:

1. Be Medically Necessary;
2. Have your knowledge and agreement while receiving the Service;
3. Be prescribed and approved by your Qualified Practitioner; and
4. Offer a medical therapeutic value at least equal to the Covered Service that would otherwise be performed or given.

We may disallow a substitute Service at any time by sending a thirty (30) day advance written notice to you and your Qualified Practitioner.

4.9 MEDICALLY NECESSARY SERVICES

We believe our Members are entitled to comprehensive medical care within the standards of good medical practice. Our medical directors and special committees of Participating Providers determine which Services are Medically Necessary using these guidelines:

- All medical Services that are appropriate and necessary for the diagnosis and treatment of symptoms, illness, disease, injury or condition that is harmful or threatening to your life or health.
- Services that are within the standard of good medical practice within the organized medical community.

Example: Your provider suggests a treatment using a machine that has not been approved for use in the United States. We probably would not pay for that treatment.

- Services at the most appropriate level that can safely be provided.

Example: You go to a hospital emergency room to have stitches removed, rather than wait for an appointment in your doctor's office. We would not pay for that visit.

- Services that are primarily for your convenience or the convenience of your provider, hospital or any other health care provider.

Example: You stay an extra day in the hospital only because the relative who will help you during recovery can't pick you up until the next morning. We may not pay for the extra day.

Although a treatment was prescribed or performed by a Qualified Practitioner, it does not necessarily mean that it is Medically Necessary under our guidelines. Obtaining confirmation of coverage from Providence Health Plan beforehand is always recommended.

4.10 HOW BENEFITS ARE APPLIED

Benefits are subject to the following provisions, if applicable, as specified in the Summary of Benefits:

1. The Deductible, if any;
2. The Copayment or Coinsurance amount; and
3. The benefit limits and/or maximums.

4.11 DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS

Understanding Deductibles

Your Out-of-Plan Deductible is the dollar amount shown on the Summary of Benefits that you are responsible to pay every Plan Year before we will provide benefits for Covered Services received from Non-Participating Providers. Certain Covered Services, like alternative care Provider Office Visits, are covered by your Out-of-Plan benefits even when your Out-of-Plan Deductible has not been met. See the Summary of Benefits for details.

Individual Out-of-Plan Deductible: An individual Out-of-Plan Deductible is the amount shown on the Summary of Benefits that must be paid by a Member before we begin to provide Out-of-Plan benefits for Covered Services received from a Non-Participating Provider for that Member.

Family Deductible: The family Out-of-Plan Deductible is the maximum deductible amount, listed on your Summary of Benefits, that a family of three (3) or more Members must pay. All amounts paid by Family Members toward their individual Out-of-Plan Deductibles apply toward the family Out-of-Plan Deductible. When the family Out-of-Plan Deductible is met, no further individual Out-of-Plan Deductibles will need to be met by any family Members.

Note: No Member will ever pay more than an individual Out-of-Plan Deductible before we begin paying for Covered Services received from Non-Participating Providers for that Member.

Your Costs that Do Not Apply to Out-of-Plan Deductibles: The following out-of-pocket costs do not apply towards your Individual and Family Out-of-Plan Deductibles:

- Services not covered by Providence Health Plan.
- Services in excess of any maximum benefit limit.
- Fees in excess of the usual, customary and reasonable (UCR) charges.
- Any penalties you must pay if you do not follow Providence Health Plan's prior authorization requirements.
- Copayments or Coinsurance for any Supplemental Benefits, such as prescription drugs, routine vision or alternative care.

Deductible Carry Over: Applicable charges used to meet any portion of the deductible during the fourth quarter of the Plan Year will be applied toward the next year's deductible, when Coinsurance is not applied to Covered Services during the fourth quarter of the Plan Year.

Understanding Out-of-Pocket Maximums

Out-of-pocket maximums are the total amount you will pay out-of-pocket in any Plan Year for Covered Services received under this Open Option Plan.

Separate In-Plan and Out-of-Plan Out-of-Pocket Maximums: Your Open Option Plan has separate In-Plan and an Out-of-Plan Out-of-Pocket Maximums, as shown in your Summary of Benefits. Separate In-Plan and Out-of-Plan out-of-pocket maximums have one maximum for payments you make for covered services when you use the In-Plan benefit and a separate out-of-pocket maximum for payments you make for covered services when you use the Out-of-Plan benefit. **These In-Plan and Out-of-Plan maximums accumulate separately and are not combined.**

Individual Out-of-Pocket Maximum: Individual Out-Of-Pocket Maximum means the total amount of Copayments and Coinsurance that an individual must pay in a Plan Year, as shown on the Summary of Benefits, before we begin to pay 100 percent* for Covered Services for the individual.

Family Out-of-Pocket Maximum: Family Out-Of-Pocket Maximum means the total amount of Copayments and Coinsurance that a family must pay in a Plan Year, as shown on the Summary of Benefits, before we begin to pay 100 percent* for Covered Services for the family. The family Out-Of-Pocket Maximum applies when there are more than two (2) Family Members enrolled on the Open Option Plan. If two (2) family members meet their individual Out-Of-Pocket Maximum, the family Out-Of-Pocket Maximum will be met and no further individual Out-Of-Pocket Maximum will need to be met by any other Family Members. If the combined Copayment and Coinsurance expenses of three (3) or more enrolled family Members meet the family Out-Of-Pocket Maximum, all remaining individual Out-Of-Pocket Maximums will be waived for the family for that Plan Year.

Note: Once any family member meets the Individual Out-of-Pocket Maximum, Providence Health Plan will begin to pay 100 percent* for Covered Services for that Member.

Your Costs that Do Not Apply to Out-of-Pocket Maximums: The following out-of-pocket costs do not apply toward your Individual and Family Out-of-Pocket Maximums:

- Services not covered by Providence Health Plan.
- Services in excess of any maximum benefit limit.
- Fees in excess of the Usual, Customary And Reasonable (UCR) charges.
- Copayments or Coinsurance for a Covered Service if indicated on the Summary of Benefits as not applicable to the Out-Of-Pocket Maximum.
- Durable medical equipment and medical supplies and devices.
- Deductibles.
- Copayments or coinsurance for any supplemental benefits your plan may have such as prescription drugs, routine vision or alternative care.
- Any penalties you must pay if you do not follow Providence Health Plan's prior authorization requirements.

***IMPORTANT NOTE:** The above listed Covered Services not applicable to the Out-Of-Pocket Maximum are NOT eligible for 100 percent benefit coverage. The Copayment or Coinsurance for these Services as shown on the Summary of Benefits remains in effect throughout the Plan Year.

5. COVERED SERVICES

This section describes Medically Necessary Services that are covered under this Open Option Plan, as specified in the Summary of Benefits.

Benefits for the treatment of illness or injury when such treatment is provided by a Qualified Practitioner include the Covered Services that are listed in this section and section 6, and shown in the Summary of Benefits.

Please refer to your Summary of Benefits for any Copayments, Coinsurance or Out-of-Plan Deductibles that may apply to Covered Services. You can view your member materials by registering for a myProvidence account on our Internet site at www.providence.org/healthplans (see section 2.4). If Providence Health Plan is required by law to modify your benefits, you will be notified in writing of the changes.

See section 6 (the Limitations section) for the specific coverage provisions that apply to the following:

- Human Organ/Tissue Transplants;
- Restoration of Head/Facial Structures and Limited Dental Services;
- Surgery and anesthesia for dental Services; and
- Alternative Care Services.

5.1 PROVIDER SERVICES

For Covered Services, received from Participating Providers, we pay the balance in full after you pay any Copayments or Coinsurance.

For Covered Services received from Non-Participating Providers, we pay the balance at UCR rates after you pay any Copayments, Coinsurance, or Out-of-Plan Deductibles. (For most visits to your Personal Physician/Provider, the Out-Of-Plan Deductible is waived.)

On your Summary of Benefits in the *Physician/Provider Services* section, your Copayment or Coinsurance information is listed for various types of provider visits.

Note: If, during the course of an office visit you receive additional Covered Services, such as laboratory services or diagnostic exams (x-rays), these Covered Services will not be included under your *Provider Office Visit* benefit. These additional Covered Services will be covered under the applicable benefit stated on the Summary of Benefits and you will be responsible for any applicable Coinsurance.

If you are unable to keep a scheduled office appointment with your provider, please try to notify that office in advance. If not, you may be charged for the missed appointment. We will not cover this expense.

5.1.1 Office Visits, Inpatient and Outpatient Hospital Visits, and Home Visits

Office visits, inpatient and outpatient Hospital visits and home visits with a Qualified Practitioner are covered as shown in your Summary of Benefits. Copayments and Coinsurances as shown in your Summary of Benefits, apply to all provider visits except those that: (a) are part of a course of maternity care; (b) are for conditions for which this Open Option Plan contains a separate and specific Copayment or Coinsurance amount; or (c) are ancillary to the visit and are billed separately by the Qualified Practitioner.

5.1.2 E-visits

E-visits are covered as shown in your Summary of Benefits. (**Out-of-Plan benefits do NOT apply to E-Visits.**)

Not all Participating Providers offer E-visits. Medical doctors (MD), Doctors of Osteopathy (DO), Nurse Practitioners (NP) and Physician Assistants (PA) are the only categories of providers approved for E-visits. Participating Providers who are authorized to provide E-visits have agreed to use appropriate Internet security technology, approved by us, to protect your information from unauthorized access or release.

To be eligible for the E-visit benefit, you must have had at least one (1) prior office visit with your Participating Provider within the last twelve (12) months.

Covered E-visits include, but are not limited to:

1. Communications of a new or existing diagnosis or treatment when the equivalent service received through an office visit would have led to a claims submission to be covered by us;
2. Communications by the Participating Provider about the management of complex chronic conditions that require extensive education and ongoing monitoring;
3. Communications of treatment for relapses of a previous condition that involve extended dialogue and significant physician time and judgment;
4. Discussion of lab results that require significant changes in medication or further testing; and
5. Extended counseling when person-to-person contact would involve an unwise delay.

Examples of e-mail communications that do not qualify as E-visits include, but are not limited to:

1. Renewing prescriptions;
2. Scheduling tests;
3. Scheduling appointments;
4. Reporting normal test results;
5. Recommending a referral to another physician;
6. A consultative message exchange from a patient who is seen in-person immediately afterward as a result of the consultative message;
7. A brief follow-up of an office visit, medical procedure or other treatment to confirm stable condition;
8. A brief discussion to confirm stability of a chronic problem and continuity of present management of the problem; and
9. All communications in connection with Mental Health or Chemical Dependency Covered Services (as provided in sections 5.4 and 5.5).

5.1.3 Administration of Anesthesia and Surgical Procedures

Benefits include the administration of anesthesia and surgical procedures, including assistant surgeon and post-operative care.

5.2 PREVENTIVE SERVICES

The following are preventive Covered Services and are covered as shown in the Summary of Benefits.

5.2.1 Periodic Physical Examinations and Well-Baby Care

Periodic physical examinations and well-baby care Services are covered **only** when received from a Personal Physician/Provider.

Your Personal Physician/Provider will determine which tests are necessary for your physical exam according to your medical history and your current health status.

Periodic physical examinations and well-baby care Services are provided in accordance with the following schedule. More frequent exams will be covered if your Personal Physician/Provider determines they are Medically Necessary. Vision and hearing screening Services are covered when performed during a periodic health examination or well-baby care examination.

Note: In order for a child to be eligible for benefits for routine newborn baby care, the child must be properly enrolled as outlined in section 3.

<u>Infants up to 24 months:</u>	Up to eight (8) well baby visits.
<u>Children:</u>	
2 years through 6 years:	One (1) exam every year.
7 years through 19 years:	One (1) exam every two (2) years.
<u>Adults:</u>	
20 years through 29 years:	One (1) exam every five (5) years.
30 years through 49 years:	One (1) exam every two (2) years.
50 years and older:	One (1) exam every year.

5.2.2 Immunizations and Vaccinations

Benefits for immunizations and vaccinations are provided in accordance with accepted medical practice. Visits to your Qualified Practitioner's office or participating pharmacy for immunizations or injections are subject to the Copayment or Coinsurance shown on the Summary of Benefits.

Covered Services do not include immunizations or vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel.

5.2.3 Women's Health Care

Female members may receive preventive women's care exams from their Personal Physician/Provider or from any other Qualified Practitioner who specializes in women's health care. Women's Health Care Providers include physicians specializing in obstetrics or gynecology, nurse practitioners, certified nurse midwives, or physician assistants specializing in women's health care. **Please note: Women's Health care Services received from a Naturopath or any other Alternative Care provider are not covered benefits.**

Gynecological Exams

Benefits for gynecological examinations include breast, pelvic and pap examinations once every Plan Year, or more frequently for women who are designated high risk. Benefits also include follow-up exams for any medical conditions discovered during an annual gynecological exam that require additional treatment.

Mammograms

Mammograms are covered on an annual basis for women over forty (40) years of age, or as recommended by a Qualified Practitioner or Women's Health Care Provider for women who are designated high risk.

Family Planning

Benefits include consultation, and contraceptive devices such as IUDs (includes insertion and removal), diaphragms and Depo-Provera to prevent pregnancy. Removal of Norplant is included when determined to be Medically Necessary.

5.2.6 Men's Health Care

Prostate Screening Exam

Benefits for prostate cancer screening examinations include a digital rectal examination and a prostate-specific antigen test, biennially for men fifty (50) and older, or as recommended by the Qualified Practitioner for men designated high risk.

5.2.7 Colorectal Cancer Screening Exams

Benefits for colorectal cancer screening examinations for Members fifty (50) and older include:

- One (1) fecal occult blood test per year, plus one (1) sigmoidoscopy every five (5) years;
- One (1) colonoscopy every ten (10) years; or
- One (1) double contrast barium enema every five (5) years.

Screening examinations and lab tests for Members designated high risk are covered as recommended by the Qualified Practitioner.

All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery benefit stated on the Summary of Benefits. Fecal occult blood tests and double contract barium enemas are covered under Lab Services.

5.2.8 Preventive Services for Members with Diabetes

Preventive services benefits for Members diagnosed with either insulin dependent or non-insulin dependent diabetes mellitus include:

- An annual dilated retinal exam by a qualified participating eye care specialist;
- An annual 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; and
- A pneumococcal vaccine every five (5) years.

5.2.9 Diabetes Self-Management Education Program

Benefits are paid in full for initial self-management education programs. You must be enrolled under this Open Option throughout the course of the program for benefits to be paid.

5.3 HOSPITAL AND SKILLED NURSING FACILITY SERVICES

A per-admission Copayment/Coinsurance or Out-of-Plan Deductible, if applicable, will be applied once per Confinement, even if you are treated in more than one (1) Hospital and/or Skilled Nursing Facility.

Covered Services do NOT include care received that consists primarily of:

1. Room and board and supervisory or custodial Services.
2. Personal hygiene and other forms of self-care.
3. Non-skilled care for senile deterioration, mental deficiency, or developmental disability.

In all cases the following are specifically excluded from the Hospital and Skilled Nursing Facility benefit:

1. Private duty nursing or a private room unless prescribed as Medically Necessary.
2. Take-home medications, supplies and equipment.
3. Personal items such as telephone, radio, television and guest meals.

5.3.1 Hospital Services

Benefits are provided as shown in the Summary of Benefits and include Services for semiprivate room accommodations, coronary care and intensive care. Other Hospital Covered Services include, but are not limited to, use of the operating room, anesthesia, dressings, medications, whole blood and blood products, oxygen, x-rays, and laboratory Services during the period of inpatient hospitalization.

5.3.2 Skilled Nursing Facility

Benefits are provided as shown in the Summary of Benefits for Covered Services from a Skilled Nursing Facility. Services must be Prior Authorized by us and prescribed by your Qualified Practitioner in order to limit Hospital Confinement by providing convalescent skilled medical and nursing Services which cannot be adequately provided through a home health program.

5.3.3 Inpatient Rehabilitation Services

Benefits are provided for physical, occupational and speech therapy Covered Services as shown in the Summary of Benefits for inpatient rehabilitation to restore or improve lost function following illness or injury. If a Member is hospitalized when rehabilitative Services begin, 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 significant improvement of a Member's condition. Benefits are subject to the limits specified in the Summary of Benefits.

5.4 MENTAL HEALTH SERVICES

Benefits are provided for Mental Health Services at the same level as and subject to limitations no more restrictive than those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions.

Covered Services include diagnostic evaluation, individual and group therapy; inpatient hospitalization as stated in section 5.3; and residential and day or partial hospitalization Services. All inpatient, residential and day or partial hospitalization treatment Services must be Prior Authorized as specified in section 4.7.

In an emergency situation, go directly to a Hospital emergency room. You do not need Prior Authorization for emergency treatment; however, we must be notified within forty-eight (48) hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue.

5.5 CHEMICAL DEPENDENCY SERVICES

Benefits are provided for Chemical Dependency Services at the same level as and subject to limitations no more restrictive than those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions.

Covered Services include diagnostic evaluation, detoxification, individual and group therapy; inpatient hospitalization as stated in section 5.3; and residential and day or partial hospitalization Services when they:

- Meet the “American Society of Addiction Medicine Placement Guidelines for Substance Related Disorders” (ASAM) criteria; and
- For all inpatient, residential and day or partial hospitalization treatment Services, are Prior Authorized as specified in section 4.7.

Treatments involving the use of Methadone are a Covered Service only when such treatment is part of a medically-supervised treatment program that has been Prior Authorized.

In an emergency situation, go directly to a Hospital emergency room. You do not need Prior Authorization for emergency treatment; however, we must be notified within forty-eight (48) hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue.

5.6 OUTPATIENT HOSPITAL SERVICES, CHEMOTHERAPY AND RADIATION THERAPY

Benefits are provided as shown in the Other Covered Services section of the Summary of Benefits and include outpatient Services at a Hospital, or Outpatient Surgical Facility, dialysis, infusion, chemotherapy and radiation therapy. See section 5.9.2 regarding injectable medications. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation and regularly scheduled therapy such as dialysis, infusion, chemotherapy, inhalation therapy, or radiation therapy, as ordered by your Qualified Practitioner. We may require that you obtain a second opinion for some elective procedures. If you do not obtain a second opinion when requested, we will not Prior Authorize the Services and you will be subject to the *Failure to Obtain Prior Authorization* penalty as explained in section 4.7.1.

Covered Services under these benefits do not include Services for Short-Term Outpatient Rehabilitation. See section 5.9.11 for those Services.

5.6.1 Self-Administered Chemotherapy

Self-administered chemotherapy agents, including oral medications and injectable medications, are covered when received from a designated participating pharmacy as shown on the Summary of Benefits.

Self-administered chemotherapy agents will be covered under your Prescription Drug Benefits, see section 5.10, when that coverage results in a lower out-of-pocket expense to the Member.

5.7 EMERGENCY CARE SERVICES

Benefits for *Emergency Services* are provided as described below and shown in the *Summary of Benefits*.

5.7.1 Emergency Care

A medical emergency is a sudden unexpected illness or injury that you believe would place your life in danger or cause serious damage to your health if you do not seek immediate medical treatment. Medical emergencies include, but are not limited to:

- Heart attack
- Stroke
- Poisoning
- Loss of consciousness
- Unexpected premature childbirth
- Acute abdominal pain
- Severe chest pain
- Serious burn
- Bleeding that does not stop
- Medically Necessary detoxification

Coverage is provided without *Prior Authorization* for Emergency Medical Screening Exams and stabilization of an Emergency Medical Condition. Hospitalization for an Emergency Medical Condition requires notification to Providence Health Plan within forty-eight (48) hours, or as soon as reasonably possible following the onset of treatment in order for coverage to continue.

The definition of an “*Emergency Medical Condition*” is a medical condition that manifests itself by symptoms of sufficient severity that a prudent lay person, possessing an average knowledge of health and medicine, would reasonably expect that failure to receive immediate medical attention would place the health of a person (or a fetus in the case of a pregnant woman) in serious jeopardy.

“*Emergency Services*” are those health care items and *Services* furnished in an emergency department. *Services* include all ancillary services routinely available to an emergency department to the extent they are required for the stabilization of the patient.

“*Emergency Medical Screening Exams*” include medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.

Your Plan benefits cover Emergency Services in the emergency room of any Hospital. **Emergency room Services are covered when your medical condition meets the guidelines for emergency care as stated above. Coverage includes Services to stabilize an Emergency Medical Condition and Emergency Medical Screening Exams.**

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 Personal Physician/Provider and show them your Member identification card.

Call your Personal Physician/Provider any time, any day of the week. Your Personal Physician/Provider, or the provider-on-call, will tell you what to do and where to go for the most appropriate care.

You are responsible for the emergency Services Copayment, as shown in the Summary of Benefits, whenever you receive Services in an emergency room, unless you are admitted to a Hospital within twenty-four (24) hours. Please be prepared to pay your Copayment, at the time you receive care. You are responsible for the Copayment for each Hospital emergency room visit.

The Plan does not pay for emergency room treatment for medical conditions that are not medical emergencies. Do not go to the emergency room for care that should take place in your provider’s office.

Routine care for sore throats, common colds, follow-up care, and prescription drug requests are not considered to be emergencies.

5.7.2 Emergency Medical Transportation

Benefits include Services for emergency medical transportation by state certified ambulance and certified air ambulance transportation. Out-of-area ambulance Services are provided for transportation to the nearest facility capable of providing the necessary care or to a facility specified by us.

5.7.3 Emergency Eye Care Services

Covered Services include the initial care for Emergency Medical Conditions resulting from an injury to or illness of the eye(s). Members may receive Services directly from an optometrist or ophthalmologist or a Hospital emergency room.

5.7.4 Emergency Detoxification Services

Medically Necessary detoxification will be treated as an emergency medical condition when the Member is not enrolled in a Chemical Dependency treatment program, as stated in section 5.5, at the time Services are received. Prior Authorization is not required for emergency treatment; however, we or our authorizing agent must be notified within forty-eight (48) hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to a Participating Provider for continued inpatient care, the cost of Medically Necessary transportation will be covered. Continuing or follow-up care is not a Covered Service unless Prior Authorized by us or our authorizing agent.

5.8 URGENT/IMMEDIATE CARE SERVICES

Urgent care is treatment you need right away for an illness or injury that is not life threatening. This includes, but is not limited to, minor sprains, minor cuts and burns, and ear, nose, and throat infections. Routine care that can be delayed until you can be seen by a physician or provider in his or her office is not urgent care.

Whenever you need urgent care, call your Personal Physician/Provider first. Your Personal Physician/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 participating urgent care center, your out-of-pocket expense will usually be lower.

You are responsible for the urgent care Copayment, as shown in the Summary of Benefits, whenever you receive Services in an urgent care clinic. Please be prepared to pay the Copayment at the time you receive care.

If you are admitted to a non-participating Hospital, you, or a relative, should call PHP within forty-eight (48) hours or as soon as reasonably possible.

If you receive urgent care Services from a non-participating facility, you must submit a claim if the facility or provider does not submit it for you. Please submit your claims to:

**Providence Health Plan, Attn: Claims Dept.
P.O. Box 4447
Portland OR 97208-4447**

Your claims should be submitted within sixty (60) days of receiving the service. To be paid, claims must be submitted within twelve (12) months of receiving the service. Please call your Customer Service Team at 1-800-878-4445 if you have questions about this benefit or if you would like additional information.

5.9 OTHER COVERED SERVICES

The following are other Covered Services and are provided as shown in the Summary of Benefits.

5.9.1 Maternity Services

Benefits include prenatal care, delivery and postnatal care. In accordance with federal and state requirements, coverage of inpatient delivery Services will not be less than forty-eight (48) hours for normal vaginal deliveries and ninety-six (96) hours for cesarean section deliveries, unless the mother and treating physician determine that an earlier discharge is appropriate.

Maternity Services for a Member who is serving as a surrogate parent are covered, except when these Services are payable under the surrogate parenting contract or agreement. See section 5.9.4 regarding diagnostic x-ray and laboratory tests, which are covered separately from the global professional fee for maternity Services.

Note: Your Open Option Plan has one (1) Copayment per pregnancy that includes all pre-natal office visits, delivery, and post-natal office visits. This copayment does not apply to other Covered Services, such as laboratory and X-ray, which you may receive for your maternity care. The specific Copayment or Coinsurance for each of these additional Services will apply. Please refer to your Summary of Benefits for details.

Newborn Nursery Care

Newborn Nursery Care is covered as shown on the Summary of Benefits provided that the newborn is properly enrolled according to the provisions of section 3.2.4.

5.9.2 Allergy Shots, Allergy Serums and Injectable Medications

Allergy shots, allergy serum, injectable medications and total parenteral nutrition (TPN) are covered as shown in your Summary of Benefits.

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.

5.9.3 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 Summary of Benefits based upon the type of Services received.

5.9.4 Diagnostic Pathology, Radiology Tests and Diagnostic Procedures

Benefits are as shown in the Summary of Benefits and include inpatient and outpatient diagnostic pathology (lab), imaging (such as PET, CT, MRI), radiology (x-ray) tests and other Medically Necessary diagnostic procedures. Covered Services include contrast materials (dyes) that may be required for a diagnostic procedure.

5.9.5 Home Health Care

Benefits for home health care Covered Services are shown in the Summary of Benefits and are described below. We will provide benefits for home health care as an alternative to hospitalization with consent of the Member. A Home Health Provider must provide Services at your home under a home health care plan. Nothing in this provision will increase benefits to cover home health care Services that are not otherwise covered under this Open Option Plan.

Each visit by a person providing Services under a home health care plan or evaluating the need for or developing a plan is considered one (1) home health care visit. Up to four (4) consecutive hours in a twenty-four (24) hour period of home health care Service is considered one (1) home health care visit. A home health care visit of more than four (4) hours is considered one (1) visit for every four (4) hours or part thereof.

Home health care will not be reimbursed unless your Qualified Practitioner certifies that the home health care Services will be provided or coordinated by a state-licensed or Medicare-certified Home Health Agency or certified rehabilitation agency.

If you were hospitalized immediately prior to the commencement of home health care, the home health care plan must be initially approved by the Qualified Practitioner who was the primary provider of Services during the hospitalization.

If the above criteria are not met, **NO** benefits will be provided under this Open Option Plan for home health care.

Rehabilitation Services provided under an authorized home health care plan will be covered as home health care Services.

Home health care benefits do **NOT** include:

1. Charges for mileage or travel time to and from your home;
2. Wage or shift differentials for Home Health Providers;
3. Charges for supervision of Home Health Providers; or
4. Services that consist principally of Custodial Care including, but not limited to, care for senile deterioration, mental deficiency, mental illness, developmental disability or care of a chronic or congenital condition on a long-term basis.

5.9.6 Hospice Care

Benefits are included for hospice care as shown in the Summary of Benefits and described below.

In addition, the following criteria must be met:

1. Your Qualified Practitioner certifies that you have a terminal illness with a life expectancy not exceeding six (6) months; and
2. The Covered Services provided are reasonable and necessary for the condition and symptoms being treated.

When the above criteria are met, we will provide benefits for a full range of Covered Services which a certified hospice care program is required to include. Covered Services include the following:

1. Nursing care provided by or under the supervision of a registered nurse;
2. Medical social Services provided by a medical social worker who is working under the direction of a physician, including counseling for the purpose of helping you and your caregivers adjust to the approaching death;
3. Services provided by your Qualified Practitioner or a physician associated with the hospice program;
4. 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;
5. 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;
6. Rehabilitation therapies provided for purposes of symptom control or to enable you to maintain activities of daily living and basic functional skills; and
7. Continuous home care during a period of crisis in which you require skilled intervention to achieve palliation or management of acute medical symptoms.

Respite care and other Services not specified above are excluded from coverage.

5.9.7 Inborn Errors of Metabolism

We will provide benefits for Covered Services as shown in the Summary of Benefits based upon the type of Services received for diagnosing, monitoring and controlling inborn errors of metabolism, including PKU, that involve amino acid, carbohydrate and fat metabolism. Covered Services include clinical visits, biochemical analysis and medical foods used in the treatment of such disorders.

5.9.8 Medical Supplies/Devices, Prosthetic Devices and Durable Medical Equipment (DME)

Benefits for medical supplies/devices, prosthetic devices, and Durable Medical Equipment (DME) are provided as shown in the Summary of Benefits when required for the standard treatment of illness or injury. We may authorize the purchase of an item if we determine the cost of purchasing an item would be less than the overall rental of the item. Services must be prescribed by your Qualified Practitioner.

The reasonable cost of repairing an item is covered as long as this cost does not exceed the purchase of a new piece of equipment or device. Items that are replaced due to loss or negligence are not covered. Items that are replaced due to the availability of a newer or more efficient model are not covered unless we determine otherwise. Repair or replacement is covered if due to normal growth processes or to a change in your physical condition due to illness or injury.

Medical Supplies/Devices

Benefits are shown in the Summary of Benefits for medical supplies or devices that are described below.

1. Casts, braces and supportive devices when used in the treatment of medical or surgical conditions in acute or convalescent stages or as immediate post-surgical care.
2. Initial and replacement contact lenses, intraocular lenses, prescription lenses or standard frame glasses, when required as a result of injury, illness or surgery, such as, but not limited to, cataract, corneal transplant surgery or for the treatment of keratoconus.
3. Rental of an oxygen unit used in the home for Members with significant hypoxemia who are unresponsive to other forms of treatment. The benefit is limited to three (3) months from the initial date of Service unless there is clinical evidence of the need to continue.
4. Removable custom shoe orthotics when required as a result of surgery, congenital defect or diabetes. Removable custom shoe orthotics are subject to the benefit maximum stated on the Summary of Benefits.
5. Other Medically Necessary supplies as ordered by your Qualified Practitioner, including, but not limited to, ostomy supplies, IUD's, diaphragms, prescribed needles, syringes and chem strips. Non-sterile examination gloves used by you or your caregiver are NOT a covered medical supply.
Diabetes supplies may be purchased through our medical supply providers or at participating pharmacies. Diabetes test strips are limited to 100 per month for insulin dependent Members and 100 every three (3) months for non-insulin dependent Members, unless otherwise prescribed by your Qualified Practitioner.
6. Medical devices surgically implanted in a body cavity to replace or aid the function of an internal organ.
7. Medically Necessary medical foods for supplementation or dietary replacement including non-prescription elemental enteral formula for home use, when determined to be Medically Necessary for the treatment of severe intestinal malabsorption. Approval of these Services will be based on criteria established by us and in accordance with regulatory requirements.

Medical Foods are defined as foods that are formulated to be consumed or administered internally under strict medical supervision, for the treatment of inborn errors of metabolism including, but not limited to: phenylketonuria (PKU); homocystinuria; citrullinemia; maple syrup disease; and pyruvate dehydrogenase deficiency. Medical foods do not include total parenteral nutrition (TPN), which is covered under section 5.9.2.

Prosthetic Devices

Benefits are provided for prosthetic devices as shown in the Summary of Benefits. Covered Services include prosthetic devices such as artificial limbs, breast implants following mastectomy, artificial eyes, and maxillofacial prosthetic devices that are Medically Necessary for the restoration and management of head and facial structures.

Durable Medical Equipment (DME)

Benefits are provided for DME as shown in the Summary of Benefits. Covered Services include Medically Necessary equipment such as a hospital bed, non-motorized wheelchair, ventilator, and similar equipment as approved by us.

Covered Services for DME do not include items that are primarily and customarily used for a non-medical purpose or which are used for environmental control or enhancement (whether or not prescribed by a physician).

5.9.9 Podiatry/Foot Services

Benefits include Covered Services of a podiatrist or other Qualified Practitioner and are provided as shown in the Physician/Provider Services section of the Summary of Benefits. Covered Services include, but are not limited to, the fitting and follow up exam for removable custom shoe orthotics when required as a result of surgery, congenital defect or diabetes. Removable custom shoe orthotics are covered as stated in section 5.9.8 (Medical Supplies/Devices). Covered Services do not include routine foot care and the removal of corns or calluses, unless you have diabetes.

5.9.10 Reconstructive Breast Surgery

Benefits for Reconstructive Surgery of the breast are covered as those Services listed in the Summary of Benefits based upon the type of Services received. Reconstructive Surgery of the breast is covered for:

1. Reconstruction of the involved breast following a mastectomy;
2. Surgery and construction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications of all stages of mastectomy, including lymphedemas.

5.9.11 Short-Term Outpatient Rehabilitation

Benefits are included for short-term outpatient physical, occupational and speech therapy Covered Services provided by a physician or licensed/registered therapist, as shown in the Summary of Benefits, 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 state in the Summary of Benefits. A visit is considered a treatment with one (1) provider (e.g., if you see a physical therapist and a speech therapist the same day at the same facility, it counts as two (2) visits as you have received treatment from two (2) providers).

Covered Services under this benefit do **NOT** include:

1. Adjustments and manipulations of any spinal or bodily area;
2. Exercise programs;
3. Rolfing, polarity therapy and similar therapies;
4. Growth and cognitive therapies, including sensory integration; and
5. Rehabilitation Services provided under an authorized home health care plan as specified in section 5.9.5.
6. Biofeedback therapy is limited to treatment of tension or migraine headaches, and is limited to 10 visits per lifetime.

5.10 **PRESCRIPTION DRUG BENEFIT**

The Prescription Drug Benefit provides coverage for prescription drugs which are Medically Necessary for the treatment of a covered illness or injury.

To be covered under this benefit, all prescription drugs must be ordered by a Qualified Practitioner and purchased at a participating pharmacy for use on an outpatient basis.

We have approximately 22,000 Providence Health Plan participating pharmacies available for Member use nationwide that provide their Services at discounted rates. To view a list of our participating pharmacies, visit our Internet site at www.providence.org/healthplans.

5.10.1 **Using Your Prescription Drug Benefit**

- Please present your Member Identification Card (ID Card) to the participating pharmacy at the time you request Services. Your Member ID Card helps streamline pharmacy costs and eliminates extra work for you, the pharmacist and us. If you have misplaced or do not have your Member ID Card with you when you need to purchase prescription drugs, please ask your pharmacist to call us.
- All Covered Services are subject to the Copayments or Coinsurance and benefit maximums listed on the Prescription Drug Summary of Benefits.
- Copayments or Coinsurance for Prescription Drug Services DO NOT APPLY to your medical Out-of-Pocket Maximum.
- Prescription Drug Benefits DO APPLY to your Lifetime Maximum Benefit.
- Copayments or Coinsurance are due at the time of purchase.
- Participating pharmacies may not charge you more than your Copayment or Coinsurance. Please contact your Customer Service team if you are asked to pay more of you or the pharmacy needs assistance processing your prescription.
- You may purchase up to a ninety (90) day supply of each maintenance drug at one time using a participating mail service pharmacy or a preferred retail pharmacy, as described in the Participating Mail Order and Preferred Retail Pharmacies section of this Handbook. Not all prescription drugs are available through our mail order and preferred retail pharmacies.
- Diabetes supplies and inhalation extender devices may be obtained at any participating pharmacy. However, these items are considered medical supplies and devices and are subject to your medical supplies and devices benefits, limitations and Copayments and/or Coinsurances. (Please refer to your medical Summary of Benefits and the Medical Supplies and Devices section of the Member Handbook for information on medical supplies and devices coverage, Copayments and Coinsurance payments.)
- Self-administered chemotherapy drugs are covered under your medical benefits, unless the benefits under this pharmacy benefit allow for lower out of pocket costs to you, in which case your pharmacy benefits will apply. (Please refer to your medical Summary of Benefits and the Self-Administered Chemotherapy section,5.6.1.)

5.10.2 **Use of Non-Participating Pharmacies**

On rare occasions, such as urgent or emergency situations, you may need to use a non-participating pharmacy. If this happens, you will need to pay full price for your prescription at the time of purchase.

To request reimbursement, you will need to fill out and submit to us a Prescription Drug Reimbursement form. Prescription Drug Reimbursement forms can be obtained from our Internet site or by contacting your Customer Service representative and requesting one be sent to you.

Please include all itemized pharmacy receipts with this form, along with an explanation of why you used a non-participating pharmacy. Submission of a claim does not guarantee payment. If your claim is approved,

you will be reimbursed the cost of your prescription, less your applicable Copayment or Coinsurance as stated on your Prescription Drug Summary of Benefits. You will be responsible for any amounts above our contracted participating pharmacy rates.

5.10.3 Prescription Drug Formulary

The **Providence Formulary** is a list of Food and Drug Administration (FDA) approved prescription brand name and generic drugs developed by physicians and pharmacists. It is designed to offer drug treatment choices for covered medical conditions. The Formulary can help you and your physician 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.

All drugs must be FDA approved, Medically Necessary, and require by law, a prescription to dispense. Not all FDA approved drugs are covered by us. Newly approved drugs will be reviewed for safety and Medical Necessity within twelve (12) months following FDA approval.

Our Formulary is updated regularly throughout the year and Qualified Practitioners are encouraged to submit suggestions for additions to us. You may obtain a copy of the Formulary from our Internet site or by contacting your Customer Service team.

If you are prescribed a prescription drug that you cannot find on our Formulary, contact your Customer Service team to verify the drug's formulary status. If the prescription medication is not on the formulary, it may be considered either a non-formulary medication or it may be excluded. Consult with your provider to see if there is a Formulary alternative that will work.

If your provider feels that the non-formulary prescription medication is Medically Necessary, or you have side effects that can not be resolved, your provider can request an exception, or Prior Authorization, for the non-formulary medication. Prescription medications that are excluded are not eligible for prior authorization. Please see sections 5.10.8 and 5.10.9 below for prescription drug limitations and exclusions. Ask your provider request an exception by submitting a Prior Authorization form to us. The Prior Authorization form should include the medical rationale as to why Formulary alternatives can not be. This Prior Authorization process must be initiated by the provider prescribing the medication.

5.10.4 Generic and Brand Name Prescription Drugs

Both generic and brand name drugs are covered benefits subject to the terms of this section and your Summary of Benefits. Generic drugs are subjected to lower Copayments than brand name drugs. Please refer to your specific Summary of Benefits for your Copayment or Coinsurance information.

Regardless of the reason or medical necessity, if you request a brand name drug, or if your provider prescribes a brand name drug when an FDA approved generic equivalent is available, you will be responsible for paying the cost difference in addition to your brand name Copayment. Your total cost, however, will never exceed the actual cost of the drug. To verify which type of prescription drug plan you are on refer to your Summary of Benefits.

5.10.5 Prescription Drug Quantity

Prescription dispensing limits, including refills, are as follows: 1) topicals, up to sixty (60) grams; 2) liquids, up to eight (8) ounces; 3) tablets or capsules, up to 100 dosage units; and 4) multi-use or unit-of-use, up to one (1) container or package; as prescribed, not to exceed a thirty-one (31) consecutive day supply, whichever is less. 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.

5.10.6 Participating Mail Order and Preferred Retail Pharmacies

You may purchase up to a ninety (90) day supply of prescribed maintenance drugs from a participating mail order or preferred retail pharmacy. (Maintenance drugs are drugs that you have been on for at least thirty (30) days and you anticipate remaining on in the future.) Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies. The following conditions apply when to Mail Order prescriptions:

1. Qualified drugs under this program will be determined by us.
2. Not all maintenance prescription drugs are available through mail order pharmacies.
3. Not all maintenance prescription drugs are available in ninety (90) day allotments.
4. Copayment(s) will be applied to the quantity stated on the appropriate Summary of Benefits and are subject to the quantity limits stated in the Prescription Quantity section 5.10.5.

When using mail order participating pharmacies, payment is required prior to processing your order. If there is a change in our participating mail service or preferred retail pharmacies, we will notify you of the change at least thirty (30) days in advance.

5.10.7 Prescription Drug Out-of-Pocket Maximum

Some of our prescription drug plans have a prescription drug Out-of-Pocket Maximum. (Refer to your specific Summary of Benefits to verify whether or not your plan has an Out-of-Pocket Maximum.) Once the combined Copayments and/or Coinsurance you pay in a Plan Year for covered prescription drugs meets the per Member or per family Out-of-Pocket Maximum, we will then pay 100% for covered prescription drugs for the remainder of that Plan Year, subject to any benefit maximums. The Prescription Drug Out-of-Pocket Maximum applies only to this supplemental benefit. It does not apply to your medical Out-of-Pocket Maximum.

5.10.8 Prescription Drug Limitations

1. All drugs must be Food and Drug Administration (FDA) approved, medically necessary, and require by law, a prescription to dispense. Not all FDA approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety and medical necessity within 12 months following FDA approval.
2. Certain drugs require Prior Authorization for medical necessity, place of therapy, length of therapy, step therapy, number of doses. Step therapy uses our pharmacy claims history to confirm if certain drugs have been tried first by a Member. If a drug has not been tried first, cannot be tried first, or if the drug history is not available, then Prior Authorization is required. For some drugs, we limit the amount of the drug we will cover. Please have your provider contact us directly for Prior Authorization. If you have questions regarding a specific drug, please call your customer service representative at the number listed on your Member ID Card;
3. Specialty drugs are injectable, infused, oral or inhaled therapies that often require specialized delivery, handling, monitoring and administration and are generally high cost. These drugs must be purchased through our designated specialty pharmacy. Due to the nature of these medications, they are not considered maintenance drugs and are limited to a thirty (30) day supply (or minimum package size to approximate a thirty (30) day supply). For a copy of our Formulary, visit our Web site at www.providence.org/healthplans, or contact your Customer Service representative;
4. Self-injectable medications are only covered if they are intended for self-administration; labeled by the FDA for self- administration; and on our Formulary;
5. Medications, drugs or hormones prescribed to stimulate growth except for children through eighteen (18) years of age when there is a laboratory confirmed diagnosis of growth hormone deficiency or when there is a specific condition approved in the medical policy, such as, but not limited to, Turner's Syndrome, Noonan Syndrome, chronic renal insufficiency. When prescribed for adults, growth hormone may be covered for conditions such as AIDS wasting, short bowel syndrome or pituitary destruction with growth hormone deficiency; and

6. Compound prescription drugs must contain at least one (1) ingredient that is an FDA-approved prescription drug in therapeutic amount and must be purchased at a participating pharmacy. Compounded drugs from bulk powders are not covered.

5.10.9 Prescription Drug Exclusions

In addition to the limitations and exclusions set forth in section 7, no Services or materials will be provided for:

1. Drugs or medicines delivered, injected, or **administered to 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 used in the treatment of the **common cold**;
4. Drugs or medications prescribed that do not relate to the treatment of a **covered illness or injury**;
5. **Devices, appliances, supplies and Durable Medical Equipment** of any type, even though such devices may require a prescription order. (Some of these items may be covered under your medical benefits. Please refer to your medical Summary of Benefits and section 5.9.8 for more information);
6. **Experimental or investigational** drugs or drugs used by a Member in a research study or in another similar investigational environment;
7. Drugs used for the treatment of **fertility/infertility**;
8. **Fluoride**, for Members over the age of ten (10) years old;
9. Drugs that are not provided in accordance with the our **formulary** management program;
10. Drugs used in the treatment of **fungal** nail conditions;
11. Drugs to stimulate **Hair Growth**, including, but not limited to **Rogaine** (topical minoxidil) or other similar drug preparations;
12. **Intrauterine devices** (IUDs), diaphragms and implantable contraceptives. (Some of these items may be covered under your medical benefits. Please refer to your medical Summary of Benefits and section 5.9.8 for more information);
13. Drugs or prescribed medications that are not **Medically Necessary** or are not provided according to the our medical policy;
14. **Methadone** for the treatment of chemical dependency. However, methadone for pain management is covered. (Methadone for the treatment of chemical dependency may be covered under your chemical dependency benefits. Please refer to section 5.5 for more information);
15. Drugs prescribed by **naturopathic** physicians (N.D.);
16. **Over-the-Counter (OTC) drugs, medications or vitamins**, that may be purchased without a Qualified Practitioner's written prescription and prescription drugs that are available in an OTC therapeutically similar form;
17. Drugs dispensed from **pharmacies outside the United States**, except when prescribed for Urgent/Immediate Care and Emergency Care medical conditions;
18. Drugs which, by law, do not require a **prescription**, except insulin;
19. Drugs placed on **prescription-only status** by state or local law;
20. **Replacement of lost** or stolen medication;
21. Drugs or medicines used to treat **sexual dysfunctions or disorders**, in either men or women, such as **Viagra** or drugs required for, or as a result of, sexual transformation;
22. Drugs used in the treatment of **drug-induced fatigue, general fatigue and idiopathic hypersomnia**;
23. **Smoking cessation drug therapy**, including **nicotine replacement therapy**. (Your Providence Health Plan health coverage provides access to discounted smoking cessation programs, including drug therapy.);
24. Drugs dispensed or compounded by a pharmacist that do not have at least one (1) FDA approved medication in **therapeutic amount**; and
25. Drugs used for **weight loss** or for **cosmetic** purposes;

26. Drugs that are not FDA approved or are designated as “less than effective” by the FDA (also known as a “DESI” drug).

5.10.10 Prescription Drug Disclaimer

We are not liable for any claim, injury, demand, or judgment based on tort or other grounds (including, but not limited to, warranty or merchantability) arising out of or in any connection with the sale, compounding, dispensing, manufacturing, or use of any prescription drug covered under this Open Option Plan.

5.11 ELECTIVE STERILIZATION

The Elective Sterilization Supplemental Benefit provides coverage for voluntary sterilization (vasectomy or tubal ligation).

All supplemental elective sterilization benefits are subject to the provisions listed in your Elective Sterilization Supplemental Summary of Benefits. Please review this document before accessing elective sterilization Services.

Please note: Providence Health Plan is a Catholic-sponsored health plan and as a matter of conscience does not offer these Services at Providence Health & Services facilities.

If you have questions regarding your supplemental elective sterilization benefit, please contact your Customer Service team.

6. LIMITATIONS

There are limitations on the benefits available under this Open Option Plan for the treatment of certain conditions and the use of certain procedures. These limitations are described in this section.

6.1 HUMAN ORGAN/TISSUE TRANSPLANTS

A transplant is defined as a procedure or series of procedures by which an organ or tissue is either;

- Removed from the body of one person (the donor) and implanted in the body of another person (the recipient who is a Member); or
- Removed from and replaced in the same person's body (a self-donor who is a Member).

The term transplant does not include Services related to the transfusion of blood or blood derivatives (except hematopoietic stem cells) or replacement of a cornea.

6.1.1 Covered Services

Covered Services for transplants are limited to Services that:

1. Are determined by us to be Medically Necessary and medically appropriate according to national standards of care;
2. Are provided at a facility approved by us or under contract with us (**Out-of-Plan benefits do NOT apply to transplant Services**);
3. Involve one (1) or more of the following organs or tissues:
 - Heart
 - Lung
 - Liver
 - Kidney
 - Pancreas
 - Small bowel
 - Autologous hematopoietic stem cell/bone marrow
 - Allogeneic hematopoietic stem cell/bone marrow; and
4. Are directly related to the transplant procedure, including Services that occur before, during and after the transplant procedure.

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 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.)

Services for donors are covered when the donor is not eligible for coverage of donation Services under any other Health Benefit Plan or government funding program. Covered Services for donors include:

1. Initial evaluation of the donor and related program administration costs;
2. Preserving the organ or tissue;
3. Transporting the organ or tissue to the transplant site;
4. Acquisition charges for cadaver or live donor;
5. Services required to remove the organ or tissue from the donor; and
6. Treatment of medical complications directly resulting from the surgery performed to obtain the organ or tissue for a period of time not to exceed thirty (30) consecutive days following that surgery.

6.1.2 Benefits for Transplant Facility Services Provided to the Organ Recipient

The Coinsurance or Copayment provisions of this Open Option Plan are waived, except as follows:

The Member/recipient is responsible for the Coinsurance or Copayment amounts, as shown in the Summary of Benefits, for inpatient Hospital Services and for outpatient facility Services that are not billed as a global fee and those amounts will apply to the Member's Out-of-Pocket Maximum.

6.1.3 Benefits for Outpatient Medications

Outpatient prescription medications for transplant-related Services, including anti-rejection (immunosuppressive) drugs are not eligible for reimbursement under the medical benefits of this Open Option Plan. Outpatient prescription medications are covered as stated under the prescription drug section, 5.10.

6.1.4 Benefits for Physician/Provider Services Provided to the Organ Recipient

Benefits for physician/provider Services are provided as shown in the Summary of Benefits. The Member/recipient is responsible for the Coinsurance or Copayment amounts for those Services, as shown in the Summary of Benefits, unless those Services are billed as a global fee with the facility Services, and those amounts will apply to the Member's Out-of-Pocket Maximum.

6.1.5 Prior Authorization

(See also section 4.7)

To qualify for coverage under this Open Option Plan, all transplant-related Services, procedures, treatment protocols and facilities must be Prior Authorized, including:

- Initial consultation;
- Evaluation;
- Transplant facilities;
- Donor evaluation;
- Donor Services;
- High dose chemotherapy administered prior to the transplant;
- HLA typing;
- Travel expenses;
- Pre-transplant care;
- Self-donation Services;
- Transplant Services; and
- Follow-up treatment.

6.1.7 Exclusions to Transplant Services

In addition to the exclusions listed in section 7, the following exclusions apply to human organ/tissue transplants:

- Any transplant procedure performed at a transplant facility that has not been approved by us;
- Any transplant that is Experimental/Investigational, as determined by us;
- Services or supplies for any transplant that are not specified as Covered Services in section 6.1, such as transplantation of animal organs or artificial organs;
- Services related to organ/tissue donation by a Member if the recipient is not a Member or the Member/recipient is not eligible for transplant benefits under this Open Option Plan; and
- Transplant-related travel expenses for the donor and the donor's and recipient's family members.

6.2 RESTORATION OF HEAD/FACIAL STRUCTURES; LIMITED DENTAL SERVICES

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, when Services are Medically Necessary for the purpose of controlling or eliminating pain, or restoring facial configuration or functions such as speech, swallowing or chewing.

Benefits are covered as those Services listed in the Summary of Benefits based upon the type of Services received.

Exclusions that apply to Restoration of Head/Facial Structures; Limited Dental Services include:

- Cosmetic Services;
- Services rendered to improve a condition that falls within the normal range of such conditions;
- Orthodontia;
- Services to treat tooth decay, periodontal conditions and deficiencies in dental hygiene;
- Removal of impacted teeth;
- 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
- Services to treat temporomandibular joint syndrome, except as specified in section 6.2.1.

6.2.1 Temporomandibular Joint (TMJ) Services

Benefits are provided for TMJ Services as shown in the Summary of Benefits based upon the type of Services received. Covered Services include:

1. A diagnostic examination including a history, physical examination and range of motion measurements, as necessary;
2. Diagnostic x-rays;
3. Physical therapy of necessary frequency and duration;
4. Therapeutic injections;
5. Therapy utilizing an appliance/splint which does not permanently alter tooth position, jaw position or bite. Benefits for this therapy will be based on the use of a single appliance/splint, regardless of the number of appliances/splints used in treatment. Coverage of the appliance/splint is under the provisions of this section and coverage is not applicable under section 5.9.8 (Medical Supplies/Devices). The benefit for the appliance splint therapy will include an allowance for diagnostic Services, office visits and adjustments; and
6. Surgical Services.

Covered Services for TMJ conditions do not include dental or orthodontia Services.

6.2.2 Outpatient Hospitalization and Anesthesia for Dental Services

Benefits for outpatient hospitalization and anesthesia for dental Services are covered as those Services listed in the Summary of Benefits based upon the type of Services received and will only be provided for Members with complicating medical conditions. Examples of these conditions include, but are not limited to:

- Developmental disabilities;
- Physical disabilities; or
- A combination of medical conditions or disabilities which cannot be managed safely and efficiently in a dental office.

Dental Services are excluded.

6.3 **ALTERNATIVE CARE**

The Alternative Care benefit provides coverage for services received from Alternative Care Providers for services that are medically necessary and are within the scope of practice of the provider involved in your care. All Alternative Care benefits are subject to any conditions and benefit limits stated in this section.

Alternative Care Services are **limited to \$2,500 per Plan Year**. Only one (1) Copayment, as shown on the Summary of Benefits is required per date of Service, regardless of the number of Covered Services received during the visit.

Alternative Care Providers

Alternative Care Services may be received from Participating or Non-Participating Providers. We have approximately 28,000 Alternative Care Participating Providers available nationwide. To find an Alternative Care Participating Provider in your area, visit our Internet site at www.providence.org/healthplans or call your Customer Service team.

You do not need a physician's referral to see an alternative care provider.

You may need to pay a provider directly for care you receive, and then submit your itemized billing statement to us for reimbursement.

6.3.1 **Acupuncture Services**

Covered services from acupuncturists:

- Office visits.
- Adjunctive therapy which may include acupressure, cupping, moxibustion, or breathing techniques. Adjunctive therapy is only covered when provided during the same course of treatment and in conjunction with acupuncture.
- All adjunctive therapy must be medically necessary for the treatment of neuromusculoskeletal disorders, nausea or pain.

The following services are NOT covered from acupuncturists:

- Adjunctive therapy not associated with acupuncture.
- Acupuncture performed with reusable needles.
- Treatment of alcohol, drug or chemical dependency in a specialized inpatient or residential facility.

6.3.2 Chiropractic 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.
- Adjunctive physiotherapy which may include ultrasound, hot packs, cold packs, electrical muscle stimulation for neuromusculoskeletal disorders.
- Related diagnostic x-rays and laboratory services.

The following services are NOT covered from chiropractors:

- Services, exams/and/or treatments for conditions other than neuromusculoskeletal disorders.
- All chiropractic appliances or durable medical equipment.
- Adjunctive physiotherapy not associated with chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissues.
- Clinical laboratory studies performed in a chiropractor's office.
- Venipuncture.

6.3.3 Naturopathic Physician Services

Naturopathic physician services are examination, clinical laboratory, diagnostic x-ray, office visit, consultation, and/or adjunctive therapeutic procedures delivered by a naturopathic physician within a course of treatment that both:

- a) includes natural treatment methods, modalities, nutritional advice, recommendation of homeopathic protocols, and
- b) excludes the prescription of pharmaceuticals (whether prescription or over-the-counter) and surgery or invasive therapeutic procedures.

All naturopathic services must be approved by Providence Health Plan or its authorizing agent as medically necessary.

Covered services from naturopathic physicians:

- Office visits/consultations, therapeutic procedures and other services provided in various combinations.
- Physical therapy which may include ultrasound; hot and cold packs; manual mechanical or electrical stimulation of the muscles; and rehabilitative exercise.
- Non-invasive adjunctive therapy modalities such as diathermy, electrical stimulation, hot and cold packs, hydrotherapy, manipulation massage, range of motion exercises and therapy.
- Related diagnostic x-rays and laboratory services.

The following services are NOT covered from naturopathic physicians:

- Immunizations, vaccinations, injectables and intravenous infusions (does not include venipuncture for the purpose of obtaining blood samples for laboratory studies).
- Topical and oral drugs, pharmaceuticals, intravenous administered treatments, minor surgery;
- Vaccines/vaccination services, homeopathic products, botanical medicine products.
- Dietary and nutritional supplements, including vitamins, minerals, herbs, herbals and herbal products, injectable supplements and injection services, or other similar products.
- Natural childbirth services.
- The following tests:

Comprehensive digestive stool analysis**Cytotoxic** food allergy test**Darkfield** examination for toxicity or parasites**EAV** and electronic tests for diagnosis and allergy**Fecal transient** and retention time**Henshaw** test**Intestinal** permeability**Loomis** 24 hour urine nutrient/enzyme analysis**Melatonin** biorhythm challenge**Salivary** caffeine clearance**Sulfate/creatinine** ratio**Urinary** sodium benzoate**Urine/saliva pH****Tryptophan** load test**Zinc** tolerancy test**6.3.4 Alternative Care General Exclusions****The following services are excluded from all Alternative Care Providers:**

- Alternative Care Services not stated as a covered service in this section.
- Hypnotherapy, behavior training, sleep therapy and weight programs.
- Education programs, self-care or self-help programs or any self-help physical training or any related diagnostic testing.
- Massage therapy.
- Hermography.
- Therapeutic modalities and procedures that are considered by us or our authorizing agent to be invasive.
- Emergency care services
- Non-emergency transportation services, including care cars or other transportation vehicles (emergency transportation is covered as stated in your Emergency Medical Transportation benefit).
- Any service or supply that is not permitted by state law with respect to the Alternative Care Provider's scope of practice.
- Services in excess of the benefit limits listed on the Alternative Care Supplemental Summary of Benefits.
- Services received from Non-Participating Providers, except as discussed in this section.

7. EXCLUSIONS

In addition to those Services listed as not covered in sections 5 and 6, the following are specifically excluded from coverage under this Open Option Plan.

General Exclusions:

We do not cover Services and supplies which:

- Are not provided;
- Are provided without charge or for which you would not be required to pay if you did not have this coverage;
- Are received before the Effective Date of Coverage;
- Are not a Covered Service or relate to complications resulting from a non-covered Service;
- Are not furnished by a Qualified Practitioner or Qualified Treatment Facility;
- 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 while you are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies, except to the extent provided by 38 U. S. C. § 1729 as it relates to non-military Services provided at a Veterans Administration Hospital or facility;
- Are provided while you are in the custody of any law enforcement authorities or while incarcerated;
- Are self-administered or provided by a person who ordinarily resides in your home or who is a member of your immediate family (parent, spouse, sibling or child);
- 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 performed in association with a Service that is not covered under this Open Option Plan;
- Are provided for any injury or illness that is sustained by an Eligible Employee or a Family Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the Eligible Employee or Family Member. This exclusion also applies to injuries and illnesses that are the subject of a disputed claim settlement under a Workers' Compensation Act or similar law. This exclusion does not apply to Members who are exempt under any Workers' Compensation Act or similar law;
- 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. Any benefits or Services provided under this Open Option 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 8.4. This exclusion also applies to Services and supplies after you have received proceeds from a settlement as specified in section 8.4.3;
- Are provided in an institution that specializes in treatment of developmental disabilities;
- Are provided for treatment or testing required by a third party or court of law which is not Medically Necessary;
- Are Experimental/Investigational;
- Are determined by us not to be Medically Necessary for diagnosis and treatment of an injury or illness;
- Are received by a qualified Member under the Oregon Death with Dignity Act;

- Punishable by up to a year's imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or mental health condition); and
- Relate to a civil revolution, 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.

Exclusions that apply to Mental Health and Chemical Dependency Services:

- Conditions that are not responsive to therapeutic management after a diagnosis is made by a physician who has treated or examined the patient, except when the treatment or Services provided are effective in maintaining existing functionality or preventing a decline in functionality;
- Conditions for mental and nervous conditions that are specified as excluded in section 17, Definitions, for Mental Health and Chemical Dependency;
- Services provided under a court order or as a condition of parole or probation or instead of incarceration which are not Medically Necessary;
- Personal growth Services such as assertiveness training or consciousness raising;
- Services related to developmental disabilities, developmental delays or learning disabilities including, but not limited to, education Services. A learning disability is a condition where there is meaningful difference between a child's current academic function and the level expected for a child that age. Educational Services include, but are not limited to, language and speech training, reading, and psychological and visual integration training as defined by the American Academy of Pediatrics Policy Statement—"Learning Disabilities, Dyslexia and Vision: A Subject Review;"
- School counseling and support Services, home-based behavioral management, household management training, peer support Services, recreation, tutor and mentor Services; independent living Services, therapeutic foster care, wraparound Services; emergency aid for household items and expenses; Services to improve economic stability, and interpretation Services;
- Evaluation or treatment for education, professional training, employment investigations, and fitness for duty evaluations;
- Community Care Facilities that provide twenty-four (24) hour non-medical residential care;
- Speech therapy, physical therapy and occupational therapy Services provided in connection with treatment of psychosocial speech delay, learning disorders, including mental retardation and motor skill disorders, and educational speech delay including delayed language development (except as provided in sections 5.3.3. and 5.9.11);
- Counseling related to family, marriage, sex and career including, but not limited to, counseling for adoption, custody, family planning or pregnancy, in the absence of a DSM-IV-TR diagnosis;
- Neurological Services and tests including, but not limited to EEGs; PET, CT and MRI imaging Services, and beam scans (except as provided in section 5.9.4);
- Services related to the treatment of sexual disorders, dysfunctions or addiction;
- Vocational, pastoral or spiritual counseling;
- Dance, poetry, music or art therapy, except as part of an approved treatment program; and
- Treatments that do not meet the national standards for Mental Health/Chemical Dependency professional practice;
- More than one (1) long-term residential Mental Health program, lasting a maximum of forty-five (45) days, within a Plan Year.

Exclusions that apply to Provider Services:

- Services of homeopaths and lay midwives.

Exclusions that apply to Reproductive Services:

- All Services related to sexual disorders or dysfunctions regardless of gender, including all Services related to a sex-change operation, including evaluation, surgery and follow-up Services;
- All Services for the treatment of infertility, including all Services related to surrogate parenting. For the purpose of this exclusion, infertility is defined as the inability to become pregnant after a year of unprotected intercourse or the inability to carry a pregnancy to term as evidenced by three (3) consecutive spontaneous abortions;
- Artificial insemination;
- Reversal of voluntary sterilization;
- Condoms and other over-the-counter birth control products;
- Home births and all related Services; and
- Services provided in a premenstrual syndrome clinic or holistic medicine clinic.

Exclusions that apply to Vision Services:

- Surgical procedures which alter the refractive character of the eye, including, but not limited to laser eye surgery, radial keratotomy, myopic keratomelelusion and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia, hyperopia or astigmatism;
- Services for routine eye care and vision care, vision exams, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in section 5.9.8; and
- Orthoptics and vision training.

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; and
- Hearing screenings and exams.

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), except as approved by us and described in section 6.2;
- Services for orthognathic surgery, except as approved by us and described in section 6.2.2; and
- Dentures and orthodontia.

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 removable custom shoe orthotics, insoles, arch supports, heel wedges, lifts and orthopedic shoes except as provided in section 5.9.8 (Medical Supplies/Devices).

Exclusions that apply to Miscellaneous Services and Items:

- Charges that are in excess of the UCR cost;
- Custodial Care;
- Transplants, except as provided in section 6.1;
- Services for Durable Medical Equipment (DME), Medical Supplies/Devices and Prosthetic Devices except as described in section 5.9.8;
- Charges for Services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to, air conditioners, air purifiers, vacuum cleaners, motorized transportation equipment, escalators, elevators, tanning beds, ramps, waterbeds, hypoallergenic mattresses, cervical pillows, swimming pools, whirlpools, spas, exercise equipment, gravity lumbar reduction chairs, home blood pressure kits, personal computers and related equipment or other similar items or equipment;
- Physical therapy and rehabilitation Services, except as provided in sections 5.3.3 and 5.9.11;
- “Telephone visits” by a physician or “environment intervention” or “consultation” by telephone for which a charge is made to the patient. “Get acquainted” visits without physical assessment or diagnostic or therapeutic intervention provided and treatment sessions by computer Internet service;
- Missed appointments;
- Non-emergency medical transportation;
- Allergy shots and allergy serums, except as provided in section 5.9.2;
- All Services and supplies related to the treatment of obesity or morbid obesity;
- Services for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas, except as provided in section 5.2.9;
- Transportation or travel time, food, lodging accommodations and communication expenses except as provided in section 6.1 and with our prior approval;
- Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
- Massage therapy;
- Light therapy for seasonal affective disorder, including equipment;
- Any vitamins, dietary supplements, and other non-prescription supplements;
- Services for genetic testing are excluded, except for Services to establish a diagnosis of a suspected congenital condition. Genetic testing is not covered for screening, to diagnose carrier states, or for informational purposes in the absence of disease;
- Services to modify the use of tobacco and nicotine, except when provided as Extra Values and Discounts, where available;
- Cosmetic Services including supplies and drugs, except as approved by us and provided in sections 5 and 6;
- Services, including routine physical examination, immunizations and vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel;
- Non-sterile examination gloves;
- Sales taxes, handling fees and similar surcharges, as explained in the definition of UCR;
- Air ambulance transportation for non-emergency situations unless approved by us in advance; and
- Nutritional counseling.

8. CLAIMS ADMINISTRATION

This section explains how we treat various matters having to do with administering your benefits and/or claims, including situations that may arise in which your health care expenses are the responsibility of a source other than us.

8.1 CLAIMS PAYMENT

Our payments for most Services are made directly to the providers of Services. Except as otherwise specifically provided in this Open Option Plan, if you are billed directly and pay for benefits which are covered by this Open Option Plan, reimbursement from us will be made only upon your written notice to us of the payment. Payment will be made to the Subscriber, subject to written notice of claim, or, if deceased, to the Subscriber's estate, unless payment to other parties is authorized in writing by you.

8.1.1 Timely Submission of Claims

We will make no payments for claims received more than 365 days after the date of Service. Exceptions will be made if we receive documentation of your legal incapacitation. Payment of claims submitted by the Oregon state Medicaid agency or a prepaid managed care health services organization described in ORS 414.725 will be made in accordance with ORS 743.847.

Payment of all claims will be made within the time limits required by OAR 836-080-0235. Please send all claims to:

Providence Health Plan
Attn: Claims Dept.
P.O. Box 3125
Portland, OR 97208-3125

8.1.2 Right of Recovery

We have the right, upon demand, to recover from a recipient the value of any benefit or claim payment that exceeded the benefits available under this Open Option Plan. Our right of recovery applies to any excess benefit, including (but not limited to) benefits obtained through fraud, error, or duplicate coverage relating to any Member. If timely repayment is not made, we have the right, in addition to any other lawful means of recovery, to deduct the value of the excess benefit from any future benefit that otherwise would have been available to the affected Member(s) from us under any contract.

8.2 COORDINATION OF BENEFITS

This Coordination of Benefits (COB) section applies when a Member has health care coverage under more than one Plan. The term “Plan” is defined below for the purposes of this COB section. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

8.2.1 Definitions Relating to Coordination of Benefits

Plan

Plan means any of the following that provides benefits or Services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

1. Plan includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage listed under (1) or (2) above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This plan

This plan means, as used in this COB section, the part of this contract to which this COB section applies and which may be reduced because of the benefits of other plans. Any other part of this contract providing health care benefits is separate from This plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules listed in section 8.2.2 determine whether This plan is a Primary plan or Secondary plan when a Member has health care coverage under more than one Plan.

When This plan is primary, we determine payment for our benefits first before those of any other Plan without considering any other Plan’s benefits. When This plan is secondary, we determine our benefits after those of another Plan and may reduce the benefits we pay so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense

Allowable expense means a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering a Member. When a Plan provides benefits in the form of Services, the reasonable cash value of each Service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering a Member is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable expense.

The following are examples of expenses that are NOT Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
2. If you are covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If you are covered by two or more Plans that provide benefits or Services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If you are covered by one Plan that calculates its benefits or Services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or Services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or Service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
5. The amount of any benefit reduction by the Primary plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Closed panel plan

A Closed panel plan is a Plan that provides health care benefits to Members primarily in the form of Services through a panel of providers that has contracted with or is employed by the Plan, and that excludes coverage for Services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial parent

A Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the Dependent child resides more than one half of the calendar year excluding any temporary visitation.

8.2.2 Order of Benefit Determination Rules

When a Member is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan.
- B.
 - 1. Except as provided in Paragraph (2) below, a Plan that does not contain a COB provision that is consistent with the State of Oregon's COB regulations is always primary unless the provisions of both Plans state that the complying plan is primary.
 - 2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 - 1. Non-Dependent or Dependent. The Plan that covers a Member other than as a Dependent, for example as an employee, Subscriber or retiree is the Primary plan and the Plan that covers the Member as a Dependent is the Secondary plan. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Member as a Dependent; and primary to the Plan covering the Member as other than a Dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Member as an employee, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
 - 2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Member is a Dependent child and is covered by more than one Plan the order of benefits is determined as follows:
 - a) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
 - i. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
 - ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
 - b) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - i. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

- ii. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
 - iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
 - iv. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the Dependent child are as follows:
 - The Plan covering the Custodial parent, first;
 - The Plan covering the spouse of the Custodial parent, second;
 - The Plan covering the non-custodial parent, third; and then
 - The Plan covering the Dependent spouse of the non-custodial parent, last.
- c) For a Dependent child covered under more than one Plan of individuals who are not the parents of the Dependent child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the Dependent child.
3. Active Employee or Retired or Laid-off Employee. The Plan that covers a Member as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same Member as a retired or laid-off employee is the Secondary plan. The same would hold true if a Member is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
 4. COBRA or State Continuation Coverage. If a Member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the Member as an employee, subscriber or retiree or covering the Member as a Dependent of an employee, Subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
 5. Longer or Shorter Length of Coverage. The Plan that covered the Member as an employee, Subscriber or retiree longer is the Primary plan and the Plan that covered the Member the shorter period of time is the Secondary plan.
 6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than we would have paid had we been the Primary plan.

8.2.3 Effect on the Benefits of this Plan

When This plan is secondary, we may reduce our benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a Member is enrolled in two or more Closed panel plans and if, for any reason, including the provision of Services by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

8.2.4 Right to Receive and Release Needed Information

Certain facts about health care coverage and Services are needed to apply this COB section and to determine benefits payable under This plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying this section and determining benefits payable under This plan and other Plans covering a Member claiming benefits. We need not tell, or get the consent of, any person to do this. Each Member claiming benefits under This plan must give us any facts we need to apply this section and determine benefits payable.

8.2.5 Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. We will not have to pay that amount again. The term “payment made” includes providing benefits in the form of Services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of Services.

8.2.6 Right of Recovery

If the amount of the payments made by us is more than we should have paid under this COB section, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or Services provided for the Member. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of Services.

8.3 NON-DUPLICATION OF COVERAGE**8.3.1 Coordination with Medicare**

In all cases, coordination of benefits with Medicare will conform with federal statutes and regulations. Medicare means Title XVIII of the Social Security Act, as enacted or amended. Medicare eligibility and how we determine our benefit limits are affected by disability and employment status. Please contact your Customer Service representative if you have questions.

8.4 THIRD-PARTY LIABILITY/SUBROGATION

The following provisions will apply when you or any other Member has received Services for a condition for which one or more third parties may be responsible. “Third party” means any person other than the Member (the first party to this Contract), and Providence Health Plan (the second party), and includes any insurance carrier providing liability or other coverage potentially available to the Member. For example, uninsured or underinsured motorist coverage, no-fault medical payments (auto, homeowners or otherwise), or other group insurance (including student plans) whether under the Member’s policy or not, are subject to recovery by us as a third-party recovery. Failure by the Member to comply with the terms of this section will be a basis for us to deny any claims for benefits arising from the condition or to terminate the Member’s coverage under this Open Option Plan as specified in section 10.2. In addition, you or the Member must execute and deliver to us and to other parties any document requested by us which may be appropriate to confirm or secure the rights and obligations of the Member and Providence Health Plan under these provisions.

8.4.1 Third-Party Liability/Subrogation and How it Affects You

Third-party liability refers to claims that are in whole or part the responsibility of someone besides Providence Health Plan or the Member. Examples of third-party liability are motor vehicle accidents, workplace injury or illness, and any other situation involving injury or illness, including wrongful death, in which the Member or the Member’s heirs, beneficiaries or relatives have a basis to bring a lawsuit or to make a claim for compensation against any person or for which the Member or the Member’s heirs, beneficiaries or relatives may receive a settlement. Once it has been established that the third party is responsible to pay and is capable of paying for the expenses for the Services caused by that third party, we will not provide benefits for the Services arising from the condition caused by that third party. Such benefits are specifically excluded from coverage under this Open Option Plan.

If we make claim payments on any Member’s behalf for any condition for which a third party is responsible, we are entitled to be repaid promptly for those payments, directly out of any recovery from the third party, including any settlement, award, verdict, payment or other monetary recovery. “Subrogation” means that we may collect directly from the third party to the extent we have paid for third-party liabilities. Because we have paid for the Member’s injuries, we, rather than the Member, are entitled to recover those expenses. Prior to accepting any settlement of the Member’s claim against a third party, the Member must notify us in writing of any terms or conditions offered in settlement and must notify the third party of our interest in the settlement established by this provision.

To the maximum extent permitted by law, we are subrogated to the Member’s rights against any third party who is responsible for the condition, have the right to sue any such third party in the Member’s name, and have a security interest in and lien upon any recovery to the extent of the amount of benefits paid by us and for our expenses in obtaining a recovery. If the Member should either decline to pursue a claim against a third party that we believe is warranted or refuse to cooperate with us in any third party claim that the Member does pursue, we have the right to pursue such claim directly, including commencing a legal action against such third party or intervening in any action that the Member may have commenced.

To accomplish this process, we need detailed information from you or from the Member. A questionnaire will be sent to the Member for this information. It should be completed and returned to our office as soon as possible to minimize any claim review delay. If you or the Member has any questions or concerns regarding the questionnaire, please contact our office. A Providence Health Plan employee who specializes in third-party liability/subrogation can discuss our procedures and what you or the Member needs to do.

8.4.2 Proceeds of Settlement or Recovery

If for any reason we are not paid directly by the third party, we are entitled to reimbursement from the Member or the Member's heirs, legal representatives, beneficiaries or relatives, and we may request refunds from the medical providers who treated the Member, in which case those providers will bill the Member for their Services. To the fullest extent permitted by law, we are entitled to the proceeds of any settlement, award, verdict, or other payment that results in a monetary recovery from a third party, whether or not responsibility is accepted or denied by the third party for the condition, whether or not such monetary recovery is described by any person as something other than a recovery of medical expenses incurred by us, and whether or not the Member is alleged to have any fault, under principles of comparative negligence or otherwise. With respect to any workers' compensation recovery, we are entitled to the proceeds whether or not the loss is deemed to be compensable under the workers' compensation laws. We are entitled to recover up to the full value of the benefits provided by us for the condition, calculated using our UCR charges for such Services, less our pro rata share of the Member's out-of-pocket expenses and attorney fees incurred in making the recovery. We are entitled to such recovery regardless of whether the Member has been fully compensated or "made whole" for the loss caused by the third party, and regardless of whether the Member has been partially compensated for such loss. We are entitled to first priority in repayment, over the Member and over any other person, for such charges.

By accepting benefits under this Open Option Plan, the Member acknowledges our first priority to this repayment and assigns to us any benefits the Member may have from other sources. The Member must cooperate fully with us in recovering amounts paid by us. If any Member seeks damages against the third party for the condition and retains an attorney or other agent for representation in the matter, that Member agrees to require the Member's attorney or agent to reimburse us directly from the settlement or recovery in the amount provided by this section.

The Member must complete our trust agreement, by which the Member and any Member's attorney (or other agent) must confirm the obligation to reimburse us directly from any settlement or recovery. We may withhold benefits for the Member's condition until a signed copy of this agreement is delivered to us. The agreement must remain in effect and we may withhold payment of benefits if, at any time, the Member's confirmation of the obligations under this section should be revoked. While this document is not necessary for us to exercise our rights under this section, it serves as a reminder to the Member and directly obligates any Member's attorney to act in accord with our rights.

8.4.3 Suspension of Benefits and Reimbursement

After the Member has received proceeds of a settlement or recovery from the third party, the Member is responsible for payment of all medical expenses for the continuing treatment of the illness or injury that Providence Health Plan would otherwise be required to pay under this Open Option Plan until all proceeds from the settlement or recovery have been exhausted. If the Member has failed to reimburse us as required by this section, we are entitled to offset future benefits otherwise payable under this Open Option Plan, or under any future contract with us, to the extent of the value of the benefits advanced under this section.

If the Member continues to receive medical treatment for the condition after obtaining a settlement or recovery from one (1) or more third parties, we are not required to provide coverage for continuing treatment until the Member proves to our satisfaction that the total cost of the treatment is more than the amount received in settlement or recovered from the third party, after deducting the cost of obtaining the settlement or recovery. We will only cover the amount by which the total cost of benefits that would otherwise be covered under this Open Option Plan, calculated using our UCR charges for such Services, exceeds the amount received in settlement or recovery from the third party. We are entitled to suspend

8. CLAIMS ADMINISTRATION

such benefits even if the total amount of such settlement or recovery does not fully compensate the Member for other damages, particularly including lost wages or pain and suffering.

Any settlement arising out of an injury or illness covered by this Open Option Plan will be deemed first to compensate you for your medical expenses, regardless of any allocation of proceeds in any settlement document that we have not approved in advance. In no event shall the amount reimbursed to us be less than the maximum permitted by law.

9. PROBLEM RESOLUTION

9.1 INFORMAL PROBLEM RESOLUTION

All of the 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 Participating Providers or payment for Services by Non-Participating Providers, please ask for our help. Your Customer Service representatives are 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.

9.2 MEMBER GRIEVANCE AND APPEAL

9.2.1 **Your Grievance and Appeal Rights**

You may, at any time during the Grievance and appeal process, seek assistance from the Oregon Insurance Division with your concerns regarding our decisions and benefits. You may contact the Oregon Insurance Division by calling (503) 947-7984 or by writing to the Oregon Insurance Division, Consumer Protection Unit, 350 Winter ST. NE, Room 440-2, Salem, OR, 97310 or through the Internet at <http://www.cbs.state.or.us/external/ins/>.

If you disagree with our decision about your medical bills or health care services you have the right to three (3) levels of internal review (an initial Grievance, a first level appeal and a second level appeal). You may request review if you believe that we have not paid a bill correctly, will not approve care you believe should be covered, or are stopping care you believe you still need. You may also file a quality of care or general complaint with us. Please include as much information as possible including the date of the incident, the names of individuals involved, and the specific circumstances. In filing a Grievance or appeal:

- You can submit written comments, documents, records and other information relating to your Grievance or appeal and we will consider that information in our review process.
- You can, upon request and free of charge, have reasonable access to and copies of the documents and records held by us that relate to your Grievance or appeal.

To the extent possible, complaints filed by telephone will be resolved at the point of Service by a Customer Service representative. All Grievances and appeals (except those involving Prior Authorizations, as discussed below) will be acknowledged within seven (7) days of receipt by us and resolved within thirty (30) calendar days or sooner depending on the clinical urgency. For an initial Grievance, we may request an additional fifteen (15) days to resolve the issue if we provide you with a notice of delay, including the reason for the delay, before the thirty (30) day period has elapsed.

Urgent Medical Conditions: If you believe your health would be seriously harmed by waiting for our decision on your Prior Authorization request, Grievance, or appeal, you may request an expedited review by call a Customer Service representative at 503-574-7500 or 1-800-878-4445 outside the Portland area. 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 seventy-two (72) hours of receiving your request.

Grievances and Appeals Involving Prior Authorizations (Non-Urgent): If your Grievance or appeal involves a Prior Authorization request for a non-urgent medical condition, we will notify you of our decision, (a) Within fifteen (15) days after we receive your request for an initial grievance or first level appeal or, (b) Within thirty (30) days of receiving your request for a second level appeal.

Grievances and Appeals Involving Concurrent Care Decisions: If we have approved an ongoing course of treatment for you and determine through our medical management procedures to reduce or terminate that course of treatment, we will provide advance notice to you of that decision. You may request reconsiderations of our decision by submitting an oral or written request at least twenty-four (24) hours before the course of treatment is scheduled to end. We will then notify you of our reconsideration decision within twenty-four (24) hours of receiving your request.

9.2.2 Initial Grievance

You must file your initial Grievance within one hundred eighty (180) days of the date on our notice of initial decision, or that initial decision will become final. Please advise us of any additional information that you want considered in the review process. If you are seeing a Non-Participating Provider, you should contact the provider's office and arrange for the necessary records to be forwarded to Providence Health Plan for the review process.

9.2.3 First Level of Appeal

If you disagree with our decision on your initial Grievance, you have the right to file a first level appeal. Your appeal and any additional information you may want reviewed must be forwarded within sixty (60) days from the date on the initial Grievance denial notice, or that denial will become final. The first level of appeal will be reviewed by Providence Health Plan staff not involved in the initial Grievance. If your appeal involves a denial of Services because they are not Medical Necessary or because they are Experimental/Investigational, you may request to have your appeal handled as a Second Level appeal.

9.2.4 Second Level of Appeal

If you are not satisfied with our decision from the first level of appeal, you may request that the Grievance Committee review your appeal. The Grievance Committee is made up of individuals not involved in the initial Grievance, and consists of Providence Health Plan staff and one (1) or more community representatives. You must request the Grievance Committee review within sixty (60) days from the date on the first level of appeal decision notice, or that first level appeal decision will become final. You may present your case to the Grievance Committee in writing, in person or by telephone conference call at our Beaverton, Oregon location. The Grievance Committee will review the documentation presented by you and send a written explanation of its decision.

9.2.5 External Review

If you are not satisfied with the decision from the Grievance Committee and your appeal involves a denial of Services because they are not Medically Necessary, not an active course of treatment for purposes of continuity of care, or because they are Experimental/Investigational **you may request an external review by an Independent Review Organization (IRO).** Your request must be made within 180 days of receipt of the Grievance Committee's final internal review decision, or that internal decision will become final. If you agree, we may waive the requirement that you exhaust the internal review process before beginning the External Review process. When the External Review process is begun, an IRO will be assigned to the case by the Director's office and we will forward complete documentation regarding the case to the IRO. The IRO is entirely independent of Providence Health Plan and performs its review under a contract with the Director's office. The IRO will notify you and us of its decisions. **We agree to be bound by and to comply with the IRO decision when the decision involves:**

- **Medically Necessary treatment;**
- **Experimental/Investigational treatment; or**
- **An active course of treatment for purposes of continuity of care.**

All costs for the handling of external review cases are paid by us and these provisions are administered in accordance with the regulatory requirements established by law and regulation in the state of Oregon.

9.2.6 How to Submit Grievances or Appeals

You may contact your Customer Service representative at 503-574-7500 or 1-800-878-4445. If you are hearing impaired and use a Teletype (TTY) Device, please call our TTY line at 503-574-8702 or 1- 888-244-6642. Written Grievances or Appeals should be sent to:

Providence Health Plan
Appeals and Grievance Department
PO Box 4327
Portland, Oregon 97208-4327

You may fax your Grievance or appeal to 503-574-8757 or 1-800-396-4778, or you may hand deliver it (if mailing use only the post office box address listed above) to the following address:

Providence Health Plan
3601 SW Murray Blvd
Beaverton, Oregon 97005

10. NEW TECHNOLOGY POLICY

10.1 NEW APPLICATION OF EXISTING TECHNOLOGY COVERAGE DETERMINATION

New technologies and new applications of existing technologies are evaluated and approved for coverage when they provide a demonstrable benefit for a particular illness or disease; are scientifically proven to be safe and most effective; and there is no equally effective or less costly alternative.

Emerging and innovative technologies are monitored by Providence Health Plan through review of trend reports from technology assessment bodies; government publications; medical journals; and information provided by providers and professional societies. A systematic process for evaluating a new technology or new application of an existing technology is proactively initiated when sufficient scientific information is available.

We have developed standards to guide the evaluation process and to ensure appropriate coverage determinations. New technology must minimally meet the following guidelines to be approved for coverage:

- Technology must improve health outcomes. The beneficial effects must outweigh any harmful effects on health outcomes. It must improve the length of life, ability to function or quality of life.
- Technology must be as beneficial as any established alternative. It should improve the net health outcome as much, or more than established alternatives.
- Application of technology must be appropriate, in keeping with good medical standards, and useful outside of investigational settings.
- Technology must meet government approval to market by appropriate regulatory agency as applicable.
- Criteria must be supported with information provided by well-conducted investigations published in peer-reviewed journals. The scientific evidence must document conclusions which are based on established medical facts.
- Opinions and evaluations of professional organizations, panels or technology assessment bodies are evaluated based on the scientific quality of the supporting evidence.

10.2 TECHNOLOGY EVALUATION PROCESS

A committee of Medical Directors with physician specialist advisors evaluates all new technology and determines coverage based on evidence for safety and efficacy. The committee relies upon a thorough review of pertinent medical literature and utilizes national technology review services which do independent analysis of a new technology.

10.3 NEW TECHNOLOGY EXPEDITED REVIEW

Requests for coverage of new technology may occur before formal policy has been developed. In these cases, an expedited review is implemented and a decision is made on a case-by-case basis. This is separate and distinct from the problem resolution procedure set forth in section 9.

11. TERMINATION OF MEMBER COVERAGE

Termination of Member coverage under this Open Option Plan will occur on the earliest of the following dates:

1. The date this Open Option Plan terminates;
2. The end of the period for which required premium was due to us and not received by us;
3. The date stated by the school district of which the Subscriber is employed when a Subscriber terminates employment;
4. Unless determined otherwise through a bargaining agreement or documented District policy in effect on June 30th, 2008, the last day of the month in which a Subscriber no longer qualifies as a Subscriber;
5. The date stated by the school district of which the Subscriber is employed when a Subscriber fails to pay required Premiums by the end of the grace period;
6. The date stated by the school district of which the Subscriber is employed when a Member enters full-time military, naval or air service, except as provided under federal USERRA requirements or similar state laws;
7. The last day of the month in which the Subscriber makes a written request for termination of coverage to be effective for the Subscriber or Member;
8. For a Family Member, the date the Subscriber's coverage terminates;
9. For a Family Member, the last day of the month in which the individual no longer qualifies as an Eligible Family Dependent;
10. For any benefit, the date the benefit is deleted from this Open Option Plan;
11. For a Member, the date of disenrollment from this Open Option Plan as described in section 11.2;
12. For a Member, the date any fraudulent information is provided; or
13. For a Member, the date we discover any breach of contractual duties, conditions or warranties, as determined by us.

You and your Employer are responsible for advising us of any changes in eligibility including the lack of eligibility of a Family Member. Coverage will not continue beyond the last date of eligibility, regardless of the lack of notice to us.

11.1 NON-LIABILITY AFTER TERMINATION

Upon termination of this Open Option Plan, we shall have no further liability beyond the effective date of the termination unless the Member continues, without lapse of membership, under another Providence Health Plan plan.

Termination During A Hospital Stay: If OEGB has immediately replaced this Open Option Plan with another group policy and a Member is hospitalized when this Open Option Plan terminates, he or she shall continue to receive benefits for Covered Services until discharged from the Hospital or until the limits of coverage under this Open Option Plan have been reached, whichever is earlier.

We will provide information to OEGB so OEGB can inform the Members of the termination of this Open Option Plan. It will be the OEGB's or your District's responsibility to inform all Members that this Open Option Plan has terminated.

11.2 DISENROLLMENT FROM THIS OPEN OPTION PLAN

“Disenrollment” means that your coverage under this Open Option Plan is terminated by us because you have engaged in fraudulent, dishonest or threatening behavior with regard to us, such as:

1. You have filed false claims with us;
2. You willfully fail to provide information or documentation required to be provided under this Open Option Plan or knowingly provide incorrect or incomplete information;
3. You have committed an act of physical or verbal abuse that poses a threat to providers, to other Members, or to Providence Health Plan employees; or
4. You have allowed a non-Member to use your Member ID Card to obtain Services.

11.3 NOTICE OF CREDITABLE COVERAGE

We will provide written certification of the Member’s period of Creditable Coverage when:

- A Member ceases to be covered under the Open Option Plan;
- A Member on COBRA coverage ceases that coverage; and
- A Member requests a Notice of Creditable Coverage within twenty-four (24) months of the termination of coverage.

12. CONTINUATION OF MEDICAL BENEFITS

If you become ineligible for coverage under this Open Option Plan you may, under certain circumstances, continue coverage. There are specific requirements, time frames and conditions that must be followed in order to be eligible for continuation of coverage and which are generally outlined below. Please contact OEGB or the Subscriber's District as soon as possible for details if you think you may qualify for continuation coverage. Also see Portability Plans in section 13. Portability coverage may be available before, during or at the end of continuation coverage.

12.1 COBRA AND STATE CONTINUATION COVERAGE

If you become ineligible you may continue coverage to the extent required by the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), and Oregon state law. OEGB requires Districts to offer COBRA coverage without regard to the size of the District. Please see section 12 for additional information regarding COBRA coverage.

12.1.1 Special Notice

If a surviving, divorced or legally separated spouse of the Subscriber is at least fifty-five (55) years old at the time of death or the dissolution or legal separation of the marriage, she or he may be eligible to continue coverage. This state-mandated continuation of coverage will terminate upon the earliest of any of the following:

1. The failure to pay Premiums when due, including any grace period;
2. The date that the Open Option Plan is terminated;
3. The date on which the surviving, divorced or legally separated spouse becomes insured under any other group health plan;
4. The date on which the surviving, divorced or legally separated spouse remarries and becomes covered under another group health plan; or
5. The date on which the surviving, divorced or legally separated spouse becomes eligible for federal Medicare coverage.

The covered Dependant children of the spouse also remain eligible for coverage with the spouse as long as they remain otherwise eligible under the terms of the Open Option Plan.

12.2 CONTINUATION OF BENEFITS DURING LABOR STRIKE

If Premiums are paid by OEGB under the terms of a collective bargaining agreement and there is a cessation of work by the employees due to a strike or lockout, this Open Option Plan will continue in effect if the Subscribers continue to pay the Premium due. The union, which represents the Subscribers, shall be responsible for collecting and paying the Premium by the due date. The amount payable by each Subscriber shall be the Premium for the category in which the Subscriber belongs plus a maximum of twenty percent (20%) increase to pay the increased cost by us. Nothing in this paragraph shall be deemed to limit any right we may have in accordance with the terms of this Open Option Plan to increase or decrease the Premium.

Coverage under this paragraph shall continue until the first of the following occurs:

1. Less than seventy-five percent (75%) of Subscribers, at the time of cessation of work, continue coverage;
2. Six (6) months after cessation of work; or
3. For an individual Subscriber and Eligible Family Dependents, the time at which the Subscriber takes full-time employment with another Employer.

12.3 CONTINUATION OF BENEFITS AFTER INJURY OR ILLNESS COVERED BY WORKERS' COMPENSATION INSURANCE

Coverage under this Open Option Plan shall be available to Subscribers who are not actively working and have filed a Workers' Compensation insurance claim. Please contact OEGB or the Subscriber's District for more information. This continuation of benefits is administered in accordance with the Coverage Extensions provision and with any state or federal continuation requirements. The Subscriber may maintain such coverage until the earlier of:

1. The Subscriber takes full-time employment with another Employer; or
2. Six (6) months from the date that the payment of Premium is made under this provision.

12.4 COVERAGE EXTENSIONS

Coverage Extension refers to the extension of full coverage for the Subscriber and any Family Members during which OEGB agrees to pay any portion of the cost of coverage under the terms of any collective bargaining agreements, policy, other agreements or Open Option Plan provisions. A Coverage Extension follows an event that meets the requirements of a Qualifying Event under federal COBRA regulations. During an Extension Period the Subscriber and any Family Members shall be considered to be COBRA Members and the Extension Period shall be counted toward the Member's maximum entitlement period for COBRA continuation coverage.

Please contact OEGB or the Subscriber's District for more information about continuation coverage.

13. COBRA

13.1 CONTINUATION OF BENEFITS

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that applies to Employers with twenty (20) or more employees. OEGB requires Districts to offer COBRA coverage without regard to the size of the District. The law requires that Employers offer employees and/or their dependents continuation of medical and dental coverage in certain instances where there is a loss of group insurance coverage.

13.2 NOTICES

For termination of employment, reduction in work hours, the death of the employee, the employee becoming covered by Medicare or loss of retiree benefits due to bankruptcy, it is the Employer's responsibility to notify the employee/dependent of the right to elect continuation coverage if there is a loss of coverage.

Under the law, the employee or a dependent has the responsibility to inform the Employer of a divorce, legal separation, or a child losing dependent status under the plan. The employee or a dependent must give this notice within sixty (60) days after the event occurs. When the Employer is notified that one of these events has happened and there is a loss of coverage, it is the Employer's responsibility to notify the employee/dependent of the right to elect continuation coverage.

The employee or dependent must elect continuation coverage within sixty (60) days after coverage ends, or if later, sixty (60) days after the date of the notice. If continuation coverage is not elected within the sixty (60) day period, coverage under this Open Option Plan will end.

If an employee or dependent is disabled on the date of termination or reduction in hours, or becomes disabled at any time during the first sixty (60) days of COBRA continuation coverage, the continuation coverage period may be extended eleven (11) additional months. To be entitled to the extended coverage period, the disabled employee/dependent must provide notice to the Employer within the initial eighteen (18) month continuation period and within sixty (60) days after the date of the determination of disability under the Social Security Act. If an individual is entitled to the extended continuation coverage period, any non-disabled dependents who are entitled to COBRA continuation coverage are also entitled to the additional eleven (11) months of coverage.

13.3 TYPE OF COVERAGE/PREMIUM PAYMENT

If continuation coverage is elected, the coverage must be identical to the coverage provided under the Employer's plan.

The individual continuing coverage is responsible for making the full monthly premium payment to OEGB or its designated third party each month. This includes the employee's share and any portion previously paid by the Employer. The amount of total monthly premium required may be obtained from OEGB or the Subscriber's District.

The initial premium payment for continuation coverage is due by the forty-fifth (45th) day after the coverage is elected. The initial premium includes charges from the date the continuation coverage began.

13.4 TERMINATION OF COBRA CONTINUATION COVERAGE

COBRA continuation coverage under this Open Option Plan will be terminated by us on the earliest date that the Member no longer qualifies for such coverage in accordance with federal COBRA regulations.

13.5 OTHER INFORMATION

Please contact the Subscriber's District or OEGB for any questions regarding COBRA continuation. Notify OEGB or your District of any changes in marital status, or a change of address.

THIS CONTINUATION OF COVERAGE EXPLANATION IS NOT INTENDED TO SATISFY THE EMPLOYER'S LEGAL REQUIREMENTS OF NOTICE AS OUTLINED IN THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA). YOU WILL RECEIVE A SEPARATE NOTICE OF CONTINUATION COVERAGE FROM THE EMPLOYER TO SATISFY THESE LEGAL REQUIREMENTS.

14. PORTABILITY

14.1 ELIGIBILITY

If your medical coverage under this Open Option Plan terminates, a choice of two (2) Portability Plans is available to provide uninterrupted coverage. To be eligible for coverage, you must meet the following requirements:

1. You must have been covered under one (1) or more Oregon group Health Benefit Plans for at least 180 days;
2. You must apply for Portability coverage not later than the sixty-third (63rd) day after termination of your group coverage; and
3. You must reside in Oregon.

You are NOT eligible for coverage under a Portability Plan if:

1. You are eligible for federal Medicare coverage;
2. You remain eligible for your prior active group coverage;
3. You are covered, or would be covered at the time Portability coverage would otherwise begin, under another group plan, policy, contract, or agreement providing benefits for Hospital or medical care; or
4. You move out of Oregon. (Please contact your Customer Service representative at the number listed on your Member ID Card for additional information).

Only persons covered under this Open Option Plan on the date coverage terminates are eligible to be covered under a Portability Plan.

The Portability Plan may be issued covering each former Member on a separate basis or it may be issued covering all former Members together. However, if termination of coverage under this Open Option Plan is due to dissolution of marriage by annulment or final divorce decree, only those persons who cease to be Eligible Family Dependents of the Subscriber are eligible for Portability Plan contract.

This privilege does NOT apply when your Employer's participation in this Open Option Plan terminates and medical coverage is replaced within thirty-one (31) days by another group insurance plan.

14.2 PORTABILITY PLANS

You will have a choice of two (2) Portability Plans, the Prevailing Benefit Plan or the Low Cost Benefit Plan, after the termination of your group coverage.

The Portability Plan is a new contract and not a continuation of your terminated group coverage. The Portability Plan's benefits and premiums will differ from those provided under your group coverage. The benefits that may be available to you will be described in benefit summary provided to you when you request an application for a Portability Plan from us. Contact your Customer Service Team at the number listed on your Member ID Card for additional information regarding the cost and benefits of the Portability Plans.

Please Note: In accordance with state mandated benefit provisions for Portability coverage, there is a twenty-four (24) month Exclusion Period for coverage of human organ/tissue transplants. The Exclusion Period can be reduced or eliminated, however, by the application of Creditable Coverage.

14.3 EFFECTIVE DATE AND PREMIUM

After you lose eligibility for coverage under this Open Option Plan, you may apply for a Portability Plan before, during or at the end of any COBRA or state continuation coverage. You have sixty-three (63) days after the date your coverage terminates to apply and pay the required Premium for your Portability Plan. The Premium must be paid in advance. You may obtain application forms from us. The Portability Plan will be effective on the day after your group medical coverage ends, if you enroll and pay the first Premium within sixty-three (63) days after the date your coverage ends.

The Premium for the Portability Plan will be the Premium charged by us as of the effective date based upon the Portability Plan, classification of risk, age and benefit amounts selected. The Premium may change as provided in the Portability Plan contract.

15. YOUR RIGHTS AND RESPONSIBILITIES

15.1 INTRODUCTION

As a Member of Providence Health Plan, you should know what to expect from us, as well as what we ask from you. Nobody knows more about your health than you and your health care provider. We take responsibility for providing the very best health care services and benefits possible; your responsibility is to know how to use them well. Please take time to read and understand your benefits. We want you to have a positive experience with Providence Health Plan, and we're ready to help in any way.

15.2 YOUR RIGHTS

Members have the right to:

- Be cared for by people who respect your privacy and dignity.
- Be informed about Providence Health Plan, our providers, and the benefits and services you have available to you as a member.
- Receive information that helps you select a participating physician or provider whom you trust and with whom you feel comfortable.
- A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Receive information and clinical guidelines from your health care provider or your health plan that will enable you to make thoughtful decisions about your health care.
- Actively participate in decisions that relate to your health and your medical care through discussions with your health care provider or through written advance directives.
- Have access to medical services that are appropriate for your needs.
- Express a concern and receive a timely response from Providence Health Plan.
- Have your claims paid accurately and promptly.
- Request a review of any service not approved, and to receive prompt information regarding the outcome.
- Make recommendations regarding the member rights and responsibilities policy.
- Refuse care from specific providers.

15.3 YOUR RESPONSIBILITIES

You have the responsibility to:

- Read and understand the information you receive about Providence Health Plan, and call Customer Service if you have questions.
- Talk openly with your physician or provider and work toward a relationship built on mutual trust and cooperation.
- Follow the treatment plan that you and your practitioner have agreed upon.
- Provide to the extent possible medical information your physicians or providers request from you.
- Do your part to prevent disease and injury. Try to make positive, healthful choices. If you do become ill or injured, seek appropriate medical care promptly.
- Treat your physicians or providers courteously.
- Make your required copayment at the time of service.
- Show your member identification card whenever you receive medical services.
- Let us know if you have concerns, or if you feel that any of your rights are being compromised, so that we can act on your behalf.

15.4 OUR RESPONSIBILITIES

Providence Health Plan has the responsibility to:

- Respect and honor your rights.
- Ensure timely access to appropriate health care services.
- Enable you to see physicians or providers who meet your needs.
- Develop a variety of benefits to serve you well.
- Assure the ongoing quality of our providers and services.
- Contract with providers who are capable, competent, and committed to excellence.
- Make it easy and convenient for you to appeal any policy or decision that you believe prevents you from receiving appropriate care.
- Provide you with accurate up-to-date information about Providence Health Plan and Participating Providers.
- Provide you with information and services designed to help you maintain good health and receive the greatest benefit from the services we offer.
- Ensure privacy and confidentiality of your medical records with access according to law.
- Ensure that your interests are well represented in decisions about Providence Health Plan policy and governance.
- Encourage physicians and providers to make medical decisions that are always in your best interest.

16. GENERAL PROVISIONS

16.1 ADDITIONAL INFORMATION AVAILABLE UPON REQUEST

The following information about Providence Health Plan is available from the Oregon Insurance Division:

- Financial information.
- Annual summary of grievances and appeals.
- Annual summary of utilization review policies.
- Annual summary of quality assessment activities.
- Annual summary of network monitoring to ensure that all covered services are reasonably accessible to members.
- A summary of the results of all federal reports and accreditation surveys available to the public.
- A summary of health promotion and disease prevention activities.

This information is available by calling 1-503-947-7984 or by writing to:

Oregon Insurance Division
Consumer Protection Unit
350 Winter Street NE, Room 440
Salem, OR 97301-3883

You also can contact them electronically at:

E-mail: dcbs.inmail@state.or.us

Internet: www.egov.oregon.gov/DCBS/insurance.shtml

16.2 SUGGESTIONS

You are encouraged to make suggestions to us. Suggestions may be oral or written and should be directed to the Customer Service team at our administrative office.

16.3 DUPLICATING PROVISIONS

If any charge is described as covered under two (2) or more benefit provisions, we will pay only under the provision allowing the greater benefit. This may require us to make a recalculation based upon both the amounts already paid and the amounts due to be paid. We have NO liability for benefits other than those this Open Option Plan provides.

16.4 PRIVACY OF MEMBER INFORMATION

Medical care is a deeply personal issue for people. All of us need to know that information about our health care is private and confidential. Providence Health Plan respects the privacy of our members and takes great care to determine when it is appropriate to share your personal health information.

We use protected health information and may share it with others as part of your treatment, payment for your treatment, and our business operations.

The following are ways we may use or share information about you:

- We will use the information to administer your plan benefits and help pay your medical bills that have been submitted to us by doctors and hospitals for payment.
- We may share your information with your doctors or hospitals to help them provide medical care to you. For example, 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. For example, 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.
- To give you information about alternative medical treatments and programs or about health related products and services that you may be interested in. For example, 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 amount of information necessary to meet any release requirement and only releases information on a need to know basis. Also, wherever feasible, identifiable information is removed from any information shared within and outside of Providence Health Plan. To secure the confidentiality of medical information, we have the following procedures in place:
 - Access to a member’s medical information held by the plan is restricted to only those Providence employees who need this information and to the member. Entries into member records are tracked for security purposes. Employees must report any security violations.
 - Unique and secured log-in names and passwords are required to access the Providence Health Plan computer system. In addition, “firewalls,” encryption and data backup systems are used. Similar strategies are used for protecting confidential information on our Internet site.
 - Providence employees are educated about privacy issues and sign a confidentiality statement upon employment, then review the information and sign again each year.
 - Each department within Providence Health Plan adopts specific policies to monitor the handling of member information.
 - Members must sign an authorization to release identifiable member information outside of Providence Health Plan or its authorized agents, except when the law requires or permits such a release or for treatment, billing and health care operations.
 - 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 Providence Health Plan members is completely protected.
 - Our agreements with Participating Providers contain confidentiality provisions that require providers treat your personal health information with the same care as Providence Health Plan.
 - 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 on our Web site at www.providence.org/healthplans, or by calling your Customer Service team.

16.5 FAILURE TO PROVIDE INFORMATION OR PROVIDING INCORRECT OR INCOMPLETE INFORMATION

Members warrant that all information contained in applications, questionnaires, forms, or statements submitted to us to be true, correct, and complete. If you willfully fail to provide information required to be provided under this Open Option Plan or knowingly provide incorrect or incomplete information, then your rights and those of your Family Members may be terminated as described in section 10.2.

In the absence of fraud, all statements made by Members shall be deemed representations and not warranties, and no statement made for the purpose of effecting coverage under this Open Option Plan shall void the Open Option Plan or reduce benefits unless contained in a written instrument signed by the Employer or the Member, a copy of which has been furnished to the Employer or to the Member.

16.6 HOLD HARMLESS

OEBB acknowledges that Providence Health Plan and its Participating Providers have entered into contracts requiring that in the event Providence Health Plan fails to pay for Services that are covered under this Open Option Plan that the Participating Providers shall not bill or otherwise attempt to collect from Members for any amounts owed to them under this Open Option Plan by Providence Health Plan, and Members shall not be liable to Participating Providers for any such sums. The Employer further acknowledges that the hold harmless agreements described in this section do not prohibit Participating Providers from billing or collecting any amounts that are payable by Members under this Open Option Plan, such as Copayment, Coinsurance and Deductible amounts.

16.7 LEGAL ACTION

No civil action may be brought under state or federal law to recover benefits from this Open Option Plan until receipt of a final decision under the Member Grievance and Appeal process specified in section 9.2 of this Open Option Plan. No civil action may be brought later than three (3) years after the date of the last decision rendered under the Member Grievance and Appeal process specified in section 9.2.

16.8 MEMBER RESPONSIBILITY

It is your responsibility to read and to understand the terms of this Open Option Plan. We will have no liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Open Option Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact us. We will assist you in understanding and complying with the terms of this Open Option Plan.

16.9 MEMBER ID CARD

The Member ID Card is issued by Providence Health Plan for Member identification purposes only. It does not confer any right to Services or other benefits under this Open Option Plan.

16.10 NON-TRANSFERABILITY OF BENEFITS

No person other than a Member is entitled to receive benefits under this Open Option Plan. Such right to benefits is nontransferable.

16.11 NO RECOURSE FOR ACTS OF PROVIDERS

The Hospitals, Skilled Nursing Facilities, physicians and other persons or organizations providing Services to you do so as independent contractors. We are not liable for any claim or demand due to damages arising out of or in any manner connected with any injuries suffered by you while receiving such Services.

16.12 NOTICE

Any notice required of us under this Open Option Plan shall be deemed to be sufficient if mailed to the Subscriber at the address appearing on the records of Providence Health Plan. Any notice required of you shall be deemed sufficient if mailed to the principal office of Providence Health Plan Health P.O. Box 3125 Portland, OR 97208.

16.13 PHYSICAL EXAMINATION AND AUTOPSY

We, at our own expense, shall have the right and opportunity to examine any Member when and as often as it may reasonably require during the pendency of any claim covered by this Open Option Plan. We also have the right to make an autopsy in case of death if not forbidden by law.

16.14 PROFESSIONAL REVIEW AND RIGHT TO EXAMINE RECORDS

All Members, by acceptance of the benefits of this Open Option Plan, shall be deemed to have consented to the examination of medical records for purposes of utilization review, quality assurance and peer review by Providence Health Plan or our designee.

All Members, for purposes other than utilization review, quality assurance and peer review, may be required to authorize any provider to give and discuss with us any information relating to any condition for which benefits are claimed under this Open Option Plan. We may transfer this information between providers or other organizations who are treating you or performing a Service on our behalf. If you do not consent to the release of records or to discussions with providers, we will be unable to determine the proper payment of any benefits and will deny the claims accordingly. Consent to the release of records and discussion with providers is a condition of payment of any benefits. Neither the consent to, nor the actual examination of the records or discussion with providers will constitute a guarantee of payment.

16.15 PRORATION OF BENEFITS

Benefits are based on a Plan Year. If the benefits under this Open Option Plan are modified, or if you change to another Open Option Plan within Providence Health Plan, the benefit limits shall be prorated accordingly.

16.16 ENDORSEMENT FOR OUT OF PLAN BENEFITS

This Endorsement is included with this Open Option Plan to extend coverage beyond our network of Participating Providers by the inclusion of Out-of-Plan benefits for Covered Services from Non-Participating Providers.

Coverage under this Endorsement is as shown for Out-of-Plan benefits in the Open Option Summary of Benefits. The following Services are **not** covered under this Endorsement and are covered under this Open Option Plan **only** as In-Plan benefits from Participating Providers:

- All E-visits (see section 5.1.2);
- All Outpatient Prescription Drug Services (see section 5.10).

17. DEFINITIONS

The following are definitions of important terms used in this Member Handbook and appear throughout as italic text.

Annual Group Enrollment Period

Annual Group Enrollment Period means the period from August 15th through September 15th each Plan Year during which Eligible Employees are given the opportunity to enroll themselves and their Eligible Family Dependents under this Open Option Plan for the upcoming Plan Year beginning on October 1st, subject to the terms and provisions as found in section 3.

Chemical Dependency

Chemical Dependency means an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological or physical adjustment to common problems. Chemical Dependency does not mean an addiction to, or dependency on tobacco, tobacco products or foods.

Coinsurance

Coinsurance means the dollar amount that you are responsible to pay to a health care provider, after your claim has been processed by us, for a Covered Service that is a percentage of the Usual, Reasonable and Customary charges for the Covered Service, as shown in the medical Summary of Benefits.

Confinement

Confinement means being a resident patient in a Hospital, Skilled Nursing Facility or Qualified Treatment Facility for at least fifteen (15) consecutive hours. Successive Confinements are considered to be one (1) Confinement if:

1. Due to the same injury or illness; and
2. Separated by fewer than thirty (30) consecutive days when you are not confined.

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 Summary of Benefits.

Cosmetic Services

Cosmetic Services means Services or surgery performed to reshape structures of the body in order to improve your appearance or self-esteem.

Covered Service

Covered Service means a Service that is:

1. Listed as a benefit in the Summary of Benefits and in sections 5 and 6;
2. Medically Necessary;
3. Not listed as an exclusion in sections 5, 6 or 7; and
4. Provided to you while you are a Member and eligible for the Service under this Open Option Plan.

Creditable Coverage

Creditable Coverage means prior health care coverage as defined in 42 U.S.C. § 300gg and includes any coverage remaining in force at the time a Member obtains new coverage. Creditable Coverage includes any group health care coverage (including the Federal Employees Health Benefits Plan and the Peace Corps), individual health care coverage, Medicare, Medicaid, TRICARE, S-CHIP, Indian Health Service or tribal organization coverage, state high-risk pool coverage, or a domestic or foreign public health plan.

Custodial Care

Custodial Care means Services that:

1. Do not require the technical skills of a licensed nurse at all times;
2. Include, but are not limited to, assistance with dressing, bathing, eating, ambulation, taking medication and incontinence care; and
3. Are not likely to improve your medical condition.

Such Services will still be considered Custodial Care even if:

1. You are under the care of a physician;
2. The Services are prescribed by a Participating Provider;
3. The Services function to support or maintain your condition; or
4. The Services are being provided by a registered nurse or licensed practical nurse.

Dependent

Dependent means a person who is supported by the Subscriber or the Subscriber's spouse. See also Eligible Family Dependent.

Director

Director means the Director of the Oregon Department of Consumer and Business Services.

District

District means a common school district, a union high school district, an education service district or a community college district.

Domestic Partner

A Domestic Partner is:

(a) A domestic partner as defined by a collective bargaining agreement or documented District policy, that is:

(A) In effect on January 31, 2008; and

(B) In compliance with applicable law, including but not limited to Chapter 99, 2007 Oregon Laws; or if no such policy or agreement exists, then

(b) An unmarried individual of the same sex who has entered into a Declaration of Domestic Partnership with the eligible employee that is recognized under Oregon law, or if allowed by documented District policy, an unmarried individual of the same or opposite sex who has entered into a partnership that meets the following criteria:

(A) Both are at least 18 years of age;

(B) Are responsible for each other's welfare and are each other's sole domestic partners;

(C) Are not married to anyone and either has not had a spouse or another domestic partner within the prior six months. If previously married, the six-month period starts on the final date of divorce;

(D) Share a close personal relationship and are not related by blood closer than would bar marriage in the State of Oregon;

(E) Have jointly shared the same regular and permanent residence for at least six months; and

(F) Are jointly financially responsible for basic living expenses defined as the cost of food, shelter and any other expenses of maintaining a household. Financial information must be provided if requested.

Note: All provisions of this Member Handbook that apply to a spouse shall apply to a Domestic Partner. Please check with your District to confirm the Domestic Partner eligibility rules that apply to you.

Durable Medical Equipment (DME)

Durable Medical Equipment means equipment that must:

1. Be able to withstand repeated use;
2. Be primarily and customarily used to serve a medical purpose; and
3. Not be generally useful to a person except for the treatment of an injury or illness.

Effective Date of Coverage

Effective Date of Coverage means the date upon which coverage under this Open Option Plan commences for a Member.

Eligible Employee

Eligible Employee means a person who is:

1. An Active Eligible Employee who is an employee of an OEGB participating District who is employed on a half-time or greater basis or is in a job-sharing position or meets the definition of an eligible employee under a separate OEGB rule or under a collective bargaining agreement; or
2. A Retired Eligible Employee who was previously an active Eligible Employee, and who is not eligible for coverage under Medicare Part A or B and is:
 - (a) Receiving a service or disability retirement allowance or pension under the Public Employees Retirement System (PERS) or under any other retirement or disability Benefit Plan or system offered by an OEGB participating District for its Employees;
 - (b) Eligible to receive a service retirement allowance under PERS and has reached earliest retirement age under ORS Chapter 238;
 - (c) Eligible to receive a pension under ORS 238A.100 to 238A.245 and has reached earliest retirement age as described in ORS 238A.165; or
 - (d) Eligible to receive a service retirement allowance or pension under another retirement benefit plan or system offered by an OEGB participating organization and has reached earliest retirement age under the plan or system.

Active Eligible Employees and Retired Eligible Employees must meet the eligibility and enrollment criteria specified in the OEGB Administrative Rules.

Eligible Family Dependent

Eligible Family Dependent means:

1. The legally recognized spouse of a Subscriber, meaning a person of the opposite sex who is a husband or wife. A relationship recognized as a marriage in another state will be recognized in Oregon even though such a relationship would not be a marriage if the same facts had been relied upon to create a marriage in Oregon. A former Spouse does not qualify as a dependent;
2. The Domestic Partner of a subscriber;
3. Unless otherwise defined by a collective bargaining agreement or documented District policy in effect on January 31, 2008, in relation to a Subscriber, the following individuals, if they are unmarried:
 - a) A biological child, step-child, or legally adopted child;
 - b) A grandchild for whom the Subscriber or the Subscriber's spouse provides at least 50% support;
 - c) A child placed for adoption with the Subscriber or Subscriber's spouse;
 - d) A child for whom the Subscriber or the Subscriber's spouse is a legal guardian and is living in the home of the Subscriber;
 - e) A child who is a legal ward by court ward by court decree or is a dependent by Affidavit of dependency and is living in the home of the Subscriber; and
 - f) A child for whom the Subscriber or the Subscriber's spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law.

Children listed under this section must not qualify as any other person's dependent child, except that a child of divorced or separated parents meeting conditions under IRC 152(e) can be treated as a dependent of both parents. In addition, children must be living in the home of the Subscriber over six months of the calendar year and the Subscriber must provide over half the yearly support.

Placement for adoption means the assumption and retention by a Subscriber or a Subscriber's spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child (an individual who has not attained eighteen (18) years of age as of the date of the adoption or placement for adoption). Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.

The limiting age for each Dependent child is age 19, and such children shall become ineligible for coverage on the last day of the month in which they attain the limiting age (e.g. their twenty-third [23rd] birthday if the limiting age is twenty-three [23]).

The limiting age for each Dependent child in regular full-time attendance at an accredited secondary school, trade school, college or university is age 26, unless otherwise specified by the Subscriber's District.. The Dependent child must be enrolled for sufficient course credits to maintain full-time status as defined by that school.

A Dependent child continues to be eligible for coverage for up to four (4) months following the close of a school term, but not beyond the limiting age and only if enrolled as a full-time student for the following school term. You must provide evidence of a Dependent child's continued eligibility to the Subscriber's District. We will notify you annually to verify continued eligibility.

A covered Dependent child who becomes an Eligible Employee through the Employer is no longer an Eligible Family Dependent under this Open Option Plan.

4. An individual specified in subsection 2(a) or 2(d) of this definition if:
- a) The individual is older than the limiting age specified above; and
 - b) The individual became developmentally or physically disabled and incapable of self-sustaining employment prior to the limiting age.

Proof of incapacity must be provided to us upon enrollment. For Eligible Family Dependents who become incapacitated while covered under this Open Option Plan, proof of incapacity must be provided within sixty (60) days of reaching the Dependent child limiting age as stated above.

Thereafter, we may not request such proof more often than annually after two (2) years from the date the first proof was furnished. If satisfactory proof is not submitted to us, the individual's coverage will not continue beyond the last date of eligibility.

Eligibility Waiting Period

Eligibility Waiting Period means the period of employment, as specified in the Member Handbook, that an otherwise Eligible Employee must complete before coverage will begin under this Open Option Plan. If an employee enrolls on a special enrollment date, any period before such special enrollment is not an Eligibility Waiting Period.

Emergency Medical Condition

Emergency Medical Condition means a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus, in the case of a pregnant woman, in serious jeopardy. Some examples are:

- Heart attack
- Stroke
- Poisoning
- Loss of consciousness
- Unexpected premature childbirth
- Acute abdominal pain
- Severe chest pain
- Serious burn
- Bleeding that does not stop
- Medically Necessary detoxification

Emergency room Services are covered when your medical condition meets the guidelines for emergency care as stated previously. Covered Services do **NOT** include Services for the inappropriate (non-emergency) use of an emergency room. This means Services which could be delayed until you can be seen in a Participating Provider's office, for example: treatment of minor illnesses such as flu or sore throat, check-ups, follow-up visits and prescription drug requests.

Emergency Medical Screening Exams

Emergency Medical Screening Exams include medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.

Emergency Services

Emergency Services means those health care items and Services furnished in an emergency department and all ancillary Services routinely available to an emergency department to the extent they are required for the stabilization of the patient.

Employer

Employer means the sponsor of this Open Option Plan, as described in the Member Handbook. To be covered under this Open Option Plan, an individual must meet the definition of Eligible Employee. The term “Oregon Educators Benefit Board (OEBB)” has the same meaning as the term “Employer” in this Member Handbook.

Endorsement

Endorsement means a document that amends and is part of this Member Handbook.

E-visit

E-visit (electronic provider communications) means a consultation through e-mail with a Participating Provider that is, in the judgment of the Participating Provider, Medically Necessary and appropriate and involves a significant amount of the Participating Provider’s time. An E-visit must relate to the treatment of a covered illness or injury. (See also section 5.1.2)

Experimental/Investigational

Experimental/Investigational means those Services that are determined by us not to be Medically Necessary or accepted medical practice in Oregon, 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 and will make this available for review upon request.

Family Member

Family Member means an Eligible Family Dependent who is properly enrolled in and entitled to Services under this Open Option Plan. For the purpose of ORS 743.730 the term “Member” satisfies the definition of “enrollee.”

Grievance

Grievance means a written complaint that may be submitted by or on behalf of a Member regarding the availability, delivery, or quality of health care Services, including a complaint regarding an adverse determination made pursuant to utilization review; claims payment; handling of reimbursement for health care Services; or matters pertaining to the contractual relationship between a Member and us.

Health Benefit Plan

Health Benefit Plan means any hospital or medical expense policy or certificate issued by a health care service contractor or health maintenance organization and any plan provided by a multiple Employer welfare arrangement or other benefit arrangement defined in the federal Employee Retirement Income Security Act (ERISA).

Home Health Provider

Home Health Provider means a public or private agency that specializes in providing skilled nursing Services and other therapeutic Services in the home and which has been licensed by the proper authority as a Home Health Agency, or is Medicare approved as a Home Health Agency.

Hospital

Hospital means an institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;
2. Has a physician or surgeon in regular attendance;
3. Provides continuous twenty-four (24) hour-a-day nursing Services;
4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
5. Is legally operated in the jurisdiction where located; and
6. Has surgical facilities on its premises or has a contractual agreement for surgical Services with an institution having a valid license to provide such surgical Services.

Hospital does NOT include an institution that is principally a rest home, nursing home, Skilled Nursing Facility, convalescent home or home for the aged. Hospital does NOT include a place principally for the treatment of alcohol or Chemical Dependency or Mental Health disorders.

In-Plan

In-Plan means the level of benefits specified in this Member Handbook for Covered Services that are provided by a Participating Provider.

Ineligible Person

Ineligible Person means any person who does not qualify as a Member under this Open Option Plan.

Lifetime Maximum Benefit

Lifetime Maximum Benefit means the total dollar amount of benefits payable by Providence Health Plan during the lifetime of a covered individual, as specified in the Summary of Benefits. During the time you are covered by an OEGB insurance carrier, including us, any dollar amount paid by any OEGB insurance carrier will count toward your Lifetime Maximum Benefit, but no amount paid by us prior to the date your coverage first became effective under OEGB will be counted.

For each Plan Year that a Member is enrolled in this Open Option Plan, we will restore to the Member's Lifetime Maximum Benefit, the following amount:

- If benefits paid by us for a Member's Covered Services in the Plan Year total \$25,000 or less, then on 1st day of the following Plan Year, we will restore the full amount of the benefits paid to the Member's Lifetime Maximum Benefit.
- If the benefits paid by us for a Member's Covered Services in the Plan Year are in excess of \$25,000, then we will restore \$25,000 to the Member's Lifetime Maximum Benefit.

Medically Necessary

Medically Necessary means Services that are in the reasonable opinion of Providence Health Plan, consistent with the written criteria regarding medically indicated Services that are maintained by us. The criteria are based on the following principles:

1. The Service is medically indicated according to the following factors:
 - The Service is necessary to diagnose or to meet the reasonable health needs of the Member;
 - The expected health benefits from the Service are clinically significant and exceed the expected health risks by a significant margin;
 - The Service is of demonstrable value and that value is superior to other Services and to the provision of no Services; and
 - Expected health benefits can include:
 - a. Increased life expectancy;
 - b. Improved functional capacity;
 - c. Prevention of complications; or
 - d. Relief of pain.
2. The Qualified Practitioner recommends the Service.
3. The Service is rendered in the most cost-efficient manner and type of setting consistent with nationally recognized standards of care, with consideration for potential benefits and harms to the patient.
4. The Service is consistent in type, frequency and duration with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by us.

In the case of a life-threatening illness, a Service that would not meet the criteria above may be considered Medically Necessary for purposes of reimbursement, if:

- It is considered to be safe and effective, as demonstrated by accepted clinical evidence reported by generally-recognized medical professionals or publications; and
- The treatment is provided in a clinically controlled research setting using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health for a life-threatening condition.

For the purpose of this exception, the term “life-threatening” means more likely than not to cause death within one (1) year of the date of the request for diagnosis or treatment.

Member

Member means a Subscriber or Eligible Family Dependent who is properly enrolled in and entitled to Services under this Open Option Plan. For the purpose of ORS 743.730 (13) the term “Member” means “enrollee.”

Member Handbook

Member Handbook means the provisions of this document and the Summary of Benefits, and any Endorsements or amendments that accompany this document.

Mental Health

Mental Health means Services related to all disorders listed in the “Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition” except for:

- Diagnostic codes 317, 318.0, 318.1, 318.2 and 319 relating to Mental Retardation;
- Diagnostic codes 315.00, 315.1, 315.2 and 315.9 relating to Learning Disorders;
- Diagnostic codes 302.2, 302.4, 302.81, 302.82, 302.83, 302.84, 302.89 and 302.9 relating to Paraphilias;
- Diagnostic codes 302.6, 302.85 and 302.9 relating to Gender Identity Disorders in Adults. This exception does not extend to children and adolescents 18 years of age or younger; and
- Diagnostic codes V15.81 through V71.09, “V” codes. This exception does not extend to children five (5) years of age or younger for diagnostic codes V61.20 (Parent-Child Relational Problem) through V61.21 (Neglect, Physical Abuse or Sexual Abuse of Child) and V62.82 (Bereavement).

Non-Participating Provider

Non-Participating Provider means an Outpatient Surgical Facility, Home Health Provider, Qualified Practitioner, Qualified Treatment Facility, Hospital or Skilled Nursing Facility that does not have a written agreement with us to participate as a health care provider under this Open Option Plan.

Open Option Plan

A Health Benefit Plan issued by Providence Health Plan to an Employer Group that provides coverage for health care services as specified in the Member Handbook.

Out-of-Plan

Out-of-Plan means the level of benefits specified in the Member Handbook and in the Summary of Benefits for Covered Services provided by Non-Participating Providers.

Out-of-Plan Deductible

1. Individual Out-of-Plan Deductible means the dollar amount, as shown in the Summary of Benefits, that a Member is responsible to pay for Covered Services received from Non-Participating Providers within a Plan Year before any benefits are provided under this Open Option Plan with respect to that Member. In the last three (3) months of a Plan Year, when Coinsurance is not applied to Covered Services, Out-of-Plan Deductible amounts paid by a Member for Covered Services during that time period will be carried forward and applied toward the Out-of-Plan Deductible for the following Plan Year.
2. Family Out-of-Plan Deductible means the maximum Out-of-Plan Deductible amount, as shown in the Summary of Benefits, that a family of three (3) or more Members must pay. All amounts paid toward the Individual Out-of-Plan Deductible by a Family Member are counted toward the Family Deductible. Once the Family Out-of-Plan Deductible is met, all Individual Deductibles are satisfied for that Plan Year. (Note: No Member will ever pay more than an Individual Out-of-Plan Deductible before the Plan begins paying for Covered Services for that Member.)
3. Out-of-Plan Deductible amounts are payable after the associated claim has been processed by us.
4. The following out-of-pocket costs do NOT apply to the Individual or Family Out-of-Plan Deductible:
 - Services not covered under this Open Option Plan;
 - Services in excess of any maximum benefit limit;
 - Fees in excess of the Usual, Customary and Reasonable (UCR) charges;
 - Any penalties that you must pay if you do not follow our Prior Authorization requirements; and
 - Copayments or Coinsurance for Supplemental Benefits included with this Open Option Plan by an Endorsement and specified in a separate Summary of Benefits.

Out-of-Pocket Maximum

Out-of-Pocket Maximum means the Plan Year threshold at which Covered Services under this Open Option Plan will begin to pay at 100%, as follows:

1. Individual Out-of-Pocket Maximum means the amount of Coinsurance and Copayments within a Plan Year, as shown in the Summary of Benefits, that a Member must pay before this Open Option Plan will provide 100% benefits* for additional Covered Services within the Plan Year.
2. Family Out-of-Pocket Maximum means the combined amount of Coinsurance and Copayments within a Plan Year, as shown in the Summary of Benefits, that all Family Members must pay before this Open Option Plan will provide 100% benefits* for additional Covered Services within the Plan Year. The family Out-of-Pocket Maximum will be satisfied if:
 - Two (2) Family Members each meet their individual Out-of-Pocket Maximum, or
 - Three (3) or more Family Members have combined Coinsurance or Copayment expenses that meet the family Out-of-Pocket Maximum amount.

The following Member-paid amounts do NOT accumulate toward the Out-of-Pocket Maximum:

1. Services not covered under this Open Option Plan;
2. Services in excess of any maximum benefit limit;
3. Fees in excess of the UCR charges;
4. Copayments or Coinsurance for a Covered Service if indicated in the Summary of Benefits as not applicable to the Out-of-Pocket Maximum;
5. Durable Medical Equipment (DME);
6. Medical Supplies and Devices;
7. Deductibles;
8. Copayments or Coinsurance for Supplemental Benefits included with this Open Option Plan by an Endorsement and specified in a separate Summary of Benefits; and
9. Any penalties a Member must pay for failure to obtain the required Prior Authorization for specified Services.

*The previously listed Covered Services not applicable to the Out-of-Pocket Maximum are **NOT** eligible for 100% benefits. The Member Copayment or Coinsurance for those Services that is shown in the Summary of Benefits remains in effect throughout the Plan Year.

Outpatient Surgical Facility

Outpatient Surgical Facility means any licensed public or private establishment that has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgery. It does NOT provide Services or accommodations for patients to stay overnight.

Participating Provider

Participating Provider means an Outpatient Surgical Facility, Home Health Provider, Qualified Practitioner, Qualified Treatment Facility, Hospital or Skilled Nursing Facility that has a written agreement with us to participate as a health care provider under this Open Option Plan. For Native American Members, Covered Services obtained through Indian Health Services are considered to be Covered Services obtained from a Participating Provider.

Personal Physician/Provider

Personal Physician/Provider means a Qualified Practitioner specializing in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; a certified nurse midwife; or a physician assistant, when providing services under the supervision of a physician; who agrees to be responsible for the Member's continuing medical care by serving as case manager. Adult female Members also may choose a Qualified Practitioner specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Personal Physician/Provider. (Note: Not all Qualified Practitioners are Personal Physicians/Providers. To obtain a listing of Participating Personal Physicians/Providers please see the Online Participating Provider Directory or call your Customer Service representative.)

Plan Year

Plan Year means the annual benefit period that applies to your coverage under this Open Option Plan. The annual benefit period is October 1 to September 30.

Portability Plans

Portability Plan means an individual plan of continuation coverage, as specified in the Oregon Insurance Code, which is available to Oregon residents who lose coverage under a group Health Benefit Plan.

Prior Authorization

Prior Authorization or Prior Authorized means a request to us or our authorizing agent by you or by a Qualified Practitioner regarding a proposed Service, for which our prior approval is granted. Prior Authorization review will determine if the proposed Service is eligible as a Covered Service or if an individual is a Member at the time of the proposed Service. Prior Authorization is subject to the terms and provisions of this Open Option Plan. Services that require Prior Authorization are shown in section 4.7.

Prior Authorized determinations are not a guarantee of benefit payment unless:

- A determination that relates to benefit coverage and medical necessity is obtained no more than thirty (30) days prior to the date of the Service; or
- A determination that relates to eligibility is obtained no more than five (5) business days prior to the date of the Service.

Providence Health Plan

Providence Health Plan means the nonprofit corporation authorized as a health care service contractor in the states of Oregon and Washington that issues this Open Option Plan to the Employer.

Qualified Practitioner

Qualified Practitioner means a physician, Women's Health Care Provider, nurse practitioner, nurse practitioner midwife, clinical social worker, physician assistant, psychologist, dentist, or other practitioner who is professionally licensed by the appropriate governmental agency to diagnose or treat an injury or illness and who provides Covered Services within the scope of that license.

Qualified Treatment Facility

Qualified Treatment Facility means a facility, institution or clinic duly licensed by the appropriate governmental agency, which is primarily established and operating within the lawful scope of its license.

Reconstructive Surgery

Reconstructive Surgery means surgery that restores features damaged as a result of injury or illness or to correct a congenital deformity or anomaly that results in a functional impairment.

Service

Service means a health care related procedure, surgery, consultation, advice, diagnosis, referrals, treatment, supply, medication, prescription drug, device or technology that is provided to a Member by a Qualified Practitioner.

Skilled Nursing Facility

Skilled Nursing Facility means a convalescent or chronic disease facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations or certified as a “killed Nursing Facility” by the Secretary of Health and Human Services pursuant to Title XVIII of the Social Security Act as amended.

Subscriber

Subscriber means an Eligible Employee who is properly enrolled in as stated in section 3.1.

Summary of Benefits

Summary of Benefits means the document with that title which is part of this Member Handbook and which summarizes the benefit provisions under this Open Option Plan.

Supplemental Benefits

Supplemental Benefits are any benefits purchased by your Employer in addition to your Open Option medical health care coverage, such as the prescription drug benefit. If your plan includes coverage for Supplemental Benefits, your Member materials will include a Summary of Benefits for each Supplemental Benefit. Not all Members have these Supplemental Benefits. Check your Summary of Benefits and Member materials to determine if your coverage includes Supplemental Benefits.

Urgent/Immediate Care

Urgent/Immediate Care means Services that are provided for unforeseen, non-life threatening, minor illnesses and injuries which require immediate attention such as ear, nose and throat infections and minor sprains and lacerations.

Urgent/Immediate Care Covered Services are provided when your medical condition meets the guidelines for Urgent/Immediate Care that have been established by us. Covered Services do **NOT** include Services for the inappropriate use of an Urgent/Immediate Care facility, such as: Services that do not require immediate attention, routine check-ups, follow-up care, and prescription drug requests.

Usual, Customary and Reasonable (UCR)

When a Service is provided by a Participating Provider, UCR means charges based on the fee that we have negotiated with Participating Providers for that Service. UCR charges will never be less than our negotiated fees.

When a Service is provided by a Non-Participating Provider, UCR charges will be based on the lesser of:

1. The fee a professional provider usually charges for a given Service;
2. A fee which falls within the range of usual charges for a given Service billed by most professional providers in the same locality who have similar training and experience;
3. A fee which is prevalent or which would not be considered excessive in a particular case because of unusual circumstances; or
4. The fee determined by comparing charges for similar Services to a national database adjusted to the geographical area where the Service was performed.

UCR charges do not include sales taxes, handling fees and similar surcharges and such taxes, fees and surcharges are not covered expenses.

Women's Health Care Provider

Women's Health Care Provider means an obstetrician or gynecologist, or physician assistant specializing in women's health, advanced registered nurse practitioner specialist in women's health or certified nurse midwife, practicing within the applicable lawful scope of practice.

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Portland Area: 503-574-7500

All Other Areas: 1-800-878-4445

Internet Address: www.providence.org/healthplans