Statewide Plan Member Handbook

For coverage beginning Jan. 1, 2010

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1. INTRODUCTION

TO: Participants

FROM: Public Employees' Benefit Board (PEBB)

The benefits described on the following pages are designed to provide you and your dependents as PEBB Participants with the best possible medical care at competitive rates. PEBB has designed this Plan and the benefits are provided by PEBB on a self-insured basis. Because this Plan is self-insured, it is subject to PEBB's funding limitations, including but not limited to legislative appropriations, PEBB fund balances, and the limits imposed by laws that apply to PEBB. PEBB has contracted with Providence Health Plan to process claims and provide customer service to Participants and to develop and manage panels of providers to participate in the Plan's network. However, Providence Health Plan does not insure or otherwise guarantee any benefits under the Plan.

Should you require additional information concerning this medical plan or any other topic related to your medical insurance, please contact the insurance company at the numbers listed below, or PEBB at 503-373-1102, or via e-mail to **inquiries.pebb@state.or.us**.

If more than one year has lapsed since the effective date of your member handbook, benefits may have changed. In all cases, benefits will be administered in accordance with the governing plan documents, insurance contracts or applicable Federal and State regulations.

Customer Service Quick Reference Guide:

Medical and prescription drug claims and benefits	503-574-7500 (local / Portland area) 1-800-878-4445 (toll-free) 503-574-8702 (TTY local) 1-888-244-6642 (TTY toll-free) **www.providence.org/healthplans**
Mail-order prescription drug services	**www.providence.org/healthplans/members/pharmacy**
Medical prior authorization requests	1-800-638-0449 (toll-free)
Mental health / chemical dependency prior authorization	1-800-711-4577 (toll-free)
Providence RN Medical Advice Line	503-574-6520 (local / Portland area) 1-800-700-0481 (toll-free)
Providence Resource Line for health education classes	503-574-6595 (local / Portland area) 1-800-562-8964 (toll-free)

2. BENEFIT SUMMARIES

FULL-TIME EMPLOYEES

IN-PLAN benefits apply to Medically Necessary Services provided by a Participating Provider in the PEBB Statewide Plan Network. OUT-OF-PLAN benefits apply to Medically Necessary Services provided by a Non-Participating Provider. Some Covered Services must be Prior Authorized (see section 3.4 for Prior Authorization requirements).

The calendar year Out-of-Pocket Maximum for IN-PLAN Covered Services is $1,000 per person / $3,000 per family, and for OUT-OF-PLAN Covered Services it is $2,000 per person / $6,000 per family. Your Copayments and Coinsurance for the following Services do **not** count toward the Out-of-Pocket Maximum: Prescription drugs, hearing exams, hearing aids, infertility and alternative care. (See the definition of Out-of-Pocket Maximum for additional details.)
The Lifetime Maximum Benefit is $2,000,000.

BENEFITS	**You Pay**: IN-PLAN	**You Pay**: OUT-OF-PLAN
Preventive Health Services		
• Periodic health exams, well-baby and well child care ages 2-19	$0	30%
(includes diagnostic X-ray and laboratory tests, and services		
covered according to schedule)	$0	30%
• Physical exam to obtain commercial driver's license		
(for employees only when required for employment; see section 5.2.1	$0	$0
for voucher requirements)		
• Routine immunizations (covered when administered in physician's	$0	30%
office or participating pharmacy)	$0	30%
• Colorectal cancer screening		
• Prostate cancer screening		
Women's Health Care Services		
• Annual calendar year gynecological exams, Pap tests	$0	30%
• Follow-up visits after annual gynecological exam	15%	30%
• Mammograms	$0	30%
Physician / Provider Services		
• Office visits to a Personal Physician/Provider	15%	30%
• Office visits to other Qualified Practitioners	15%	30%
• E-visits to a Participating Provider	$0	Not Covered
• Inpatient Hospital visits	15%	30%
• Inpatient surgery and anesthesia	15%	30%
• Surgery and anesthesia performed in a provider's office	15%	30%
• Allergy shots, serums and injectable medications	15%	30%
• Family planning and related Services	15%	30%
• Nutritional counseling Services	15%	30%
• Alternative care visits from any licensed Acupuncturist, Chiropractor or Naturopathic Physician*	30%	30%
Hospital and Inpatient Services		
• Acute care, intensive care or isolation unit	15%	30%
• Rehabilitative care (30 days per calendar year; 60 days for head and spinal cord injuries)	15%	30%
• Skilled Nursing Facility (180 days per calendar year)	15%	30%
• Bariatric surgery (In-Plan coverage only)	15%	Not Covered
Maternity Services		
• Prenatal visits, delivery and postnatal visits	15%	30%
• Hospital Services related to delivery	15%	30%
• Hospital Services related to routine newborn nursery care	15%	30%
• Infertility Services*	50%	50%

*Does not apply to Out-of-Pocket Maximum

Medical Supplies including Durable Medical Equipment, appliances and prosthetic devices	15%	30%
Diabetes Supplies and Insulin	$0	$0
Emergent/Urgent & Ambulance Services (the Coinsurance shown is waived if admitted to Hospital within 24 hours)		
• Emergency Services (for Emergency Medical Conditions only)	15%	15%
• Urgent care Services (for non life-threatening illness or minor injury)	15%	30%
• Ambulance Services (for emergency transportation only)	15%	15%
Other Covered Services		
• X-ray and lab Services	15%	30%
• Outpatient rehabilitative Services (60 visits per calendar year)	15%	30%
• Outpatient surgery, dialysis, chemotherapy, radiation therapy and cardiac rehabilitation	15%	30%
• Temporomandibular joint (TMJ) Services	15%	30%
• Home health care and home infusion Services (limited to 180 visits per calendar year)	15%	30%
• Hospice care	$0	$0
• Hearing exams (once per calendar year)*	15%	30%
• Hearing aids (limited to $4000 per person every 4 calendar years)*	10%	10%
• Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy)		
- Generic drugs	$10	N/A
- Formulary brand-name drugs	$50	N/A
- Non-formulary brand-name drugs	$100	N/A
Mental Health / Chemical Dependency Services		
• Outpatient Services	15%	30%
• Inpatient Hospital Services and Residential/Day Services (Residential Services limited to 180 days per calendar year)	15%	30%

*Does not apply to Out-of-Pocket Maximum

PRESCRIPTION DRUG BENEFIT SUMMARY
(See additional details in section 5.10)

Retail: For prescriptions filled at a participating retail pharmacy, **for up to a 34-day supply**:

- **Value drugs**: $0 Copayment
- **Generic drugs**: $5 Copayment
- **Preferred (formulary) brand-name drugs**: $15 Copayment
- **Non-preferred (non-formulary) brand-name drugs**: $50 Copayment or 50% Coinsurance, whichever is greater, **when a generic equivalent is not available** (see note below)

Mail Order: For prescriptions filled via the mail order provisions of this Plan, **for up to a 90-day supply**:

- **Value drugs**: $0 Copayment
- **Generic drugs**: $12.50 Copayment
- **Preferred (formulary) brand-name drugs**: $37.50 Copayment
- **Non-preferred (non-formulary) brand-name drugs**: $125 Copayment or 50% Coinsurance, whichever is greater, **when a generic equivalent is not available** (see note below)

Important Notes:

- An exception process is available if the prescribing provider believes that it is Medically Necessary for You to use a non-preferred (non-formulary) brand-name drug instead of a preferred (formulary) brand-name or generic drug. A request for medical exception that explains why the drug substitution is medically appropriate may be submitted by Your provider to Providence Health Plan. If the request is approved, the benefit for **preferred** (formulary) brand-name drugs will apply and You will be responsible for the difference in cost between the non-preferred (non-formulary) brand drug and the generic drug. If the request is denied, the appeal rights described in section 9 will apply.
- If You request, or Your physician prescribes, a non-preferred (non-formulary) brand-name drug when a generic equivalent is available, You will be responsible for the difference Copayment. This provision applies to approved copay exceptions.
- Copayments and any difference in cost payments for covered prescription drugs do **not** apply to Your calendar year medical Out-of-Pocket Maximum.
- Buproprion and over-the-counter nicotine gum and patches are covered under the value Copayment.
- Chantix is covered under the generic copayment.
- Value drugs are commonly used medications for treating chronic conditions such as diabetes, high blood pressure, high cholesterol, heart disease, depression, asthma and other breathing disorders. These medications may be generic or brand-name and are considered first-line treatments for many conditions. The drugs can be found on the Providence Health Plan formulary.
- Pharmacy Services do not apply to the Out-of-Pocket Maximum.

PART TIME EMPLOYEES & RETIREES

IN-PLAN benefits are provided for Medically Necessary Services when provided by a Participating Provider in the PEBB Statewide Plan Network. **OUT-OF-PLAN** benefits are provided when Covered Services are received from Non-Participating Providers. Benefits for Non-Participating Providers are provided at Usual, Customary and Reasonable (UCR) charges. Some Covered Services must be Prior Authorized or coverage will be denied.

This Plan pays 50% of the first $1,000 per Participant and the first $3000 per family (3 or more Family Members) of Covered Services received from Participating & Non-Participating Providers in a calendar year. **After that, the calendar year IN-PLAN Out-Of-Pocket Maximum payable by you for Covered Services is $2,000 per person/$6,000 per family; OUT-OF-PLAN is $4,000 per person/$12,000 per family**. Your Copayments and Coinsurance for the following Services do **not** count toward the Out-of-Pocket Maximum: Prescription drugs, hearing exams, hearing aids, infertility and alternative care. (See the definition of Out-of-Pocket Maximum for additional details.) **The Lifetime Maximum Benefit is $2,000,000**.

BENEFITS	**You Pay**: **IN-PLAN**	**You Pay**: **OUT-OF-PLAN**
Preventive Health Services		
• Periodic health exams, well-baby and well child care ages 2-19 (includes diagnostic x-ray and laboratory tests, services covered according to schedule)	$0	50%
• Physical exam to obtain commercial driver's license (for employees only when required for employment; see section 5.2.1 for voucher requirements)	$0	50%
• Routine immunizations/shots (covered when administered in physician's office or participating pharmacy)	$0	50%
• Colorectal cancer screening	$0	50%
• Prostate cancer screening	$0	50%
Women's Health Care Services		
• Annual calendar year gynecological exams, Pap tests	$0	50%
• Follow-up visits after annual gynecological exam	20%	50%
• Mammograms	$0	50%
Physician / Provider Services		
• Office visits to a Personal Physician/Provider	20%	50%
• Office visits to other Qualified Practitioners	20%	50%
• E-visits to a Participating Provider	20%	Not Covered
• Inpatient Hospital visits	20%	50%
• Inpatient surgery and anesthesia	20%	50%
• Surgery and anesthesia performed in a provider's office	20%	50%
• Allergy shots, serums and injectable medications	20%	50%
• Family planning and related Services	20%	50%
• Nutritional counseling Services	20%	50%
• Alternative care visits from any licensed Acupuncturist, Chiropractor or Naturopathic Physician*	50%	50%
Hospital and Inpatient Services		
• Acute care, intensive care or isolation unit	20%	50%
• Rehabilitative care (30 days per calendar year; 60 days for head and spinal cord injuries)	20%	50%
• Skilled Nursing Facility (180 days per calendar year)	20%	50%
• Bariatric surgery (In-Plan coverage only)	20%	Not Covered
Maternity Services		
• Prenatal visits, delivery and postnatal visits	20%	50%
• Hospital Services relating to delivery	20%	50%
• Hospital Services relating to routine newborn nursery care	20%	50%
• Infertility Services*	50%	50%

*Does not apply to Out-of-Pocket Maximum

Medical Supplies including Durable Medical Equipment, appliances, and prosthetic devices	20%	50%
Diabetes Supplies and Insulin	$0	$0
Emergent/Urgent & Ambulance Services (the Coinsurance shown is waived if admitted to Hospital within 24 hours)		
• Emergency Services (for Emergency Medical Conditions only)	20%	20%
• Urgent care Services (for non life-threatening illness or minor injury)	20%	50%
• Ambulance Services (for emergency transportation only)	20%	20%
Other Covered Services		
• X-ray and lab Services	20%	50%
• Outpatient rehabilitative Services (60 visits per calendar year)	20%	50%
• Outpatient surgery, dialysis, chemotherapy, radiation therapy and cardiac rehabilitation	20%	50%
• Temporomandibular joint (TMJ) Services	20%	50%
• Home health care and home infusion Services (limited to 180 visits per calendar year)	20%	50%
• Hospice care	$0	$0
• Hearing exams (once per calendar year)*	15%	50%
• Hearing aids (limited to $4000 per person every 4 calendar years)*	10%	10%
• Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy)		
- Generic drugs	$10	N/A
- Formulary brand-name drugs	$50	N/A
- Non-formulary brand-name drugs	$100	N/A
Mental Health / Chemical Dependency Services		
• Outpatient Services	20%	50%
• Inpatient Hospital Services and Residential/Day Services (Residential Services limited to 180 days per calendar year)	20%	50%

*Does not apply to Out-of-Pocket Maximum

PRESCRIPTION DRUG BENEFIT SUMMARY
(See additional details in section 5.10)

Retail: For prescriptions filled at a participating retail pharmacy, **for up to a 34-day supply**:

- **Value drugs**: $0 Copayment
- **Generic drugs**: $10 Copayment
- **Preferred (formulary) brand-name drugs**: 20% Copayment
- **Non-preferred (non-formulary) brand-name drugs**: $50 Copayment or 50% Coinsurance, whichever is greater, **when a generic equivalent is not available** (see note below)

Mail Order: For prescriptions filled via the mail order provisions of this Plan, **for up to a 90-day supply**:

- **Value drugs**: $0 Copayment
- **Generic drugs**: $25 Copayment
- **Preferred (formulary) brand-name drugs**: $62.50 Copayment
- **Non-preferred (non-formulary) brand-name drugs**: $125 Copayment **when a generic equivalent is not available** (see note below)

Important Notes:

- An exception process is available if the prescribing provider believes that it is Medically Necessary for You to use a non-preferred (non-formulary) brand name drug instead of a preferred (formulary) brand name or generic drug. A request for medical exception that explains why the drug substitution is medically appropriate may be submitted by Your provider to PHP. If the request is approved, the benefit for **preferred** (formulary) brand-name drugs will apply and You will be responsible for the difference in cost between the non-preferred (non-formulary) brand drug and the generic drug. If the request is denied, the appeal rights described in section 9 will apply.
- If You request, or Your physician prescribes, a non-preferred (non-formulary) brand name drug when a generic equivalent is available, in addition to the brand Copayment. This also applies to approved Copay exceptions.
- Copayments and any difference in cost payments for covered prescription drugs do **not** apply to Your calendar year medical Out-of-Pocket Maximum.
- Buproprion and over-the-counter nicotine gum and patches are covered under the value Copayment.
- Chantix is covered under the generic copayment.
- Value drugs are commonly used medications for treating chronic conditions such as diabetes, high blood pressure, high cholesterol, heart disease, depression, asthma and other breathing disorders. These medications may be generic or brand-name and are considered first-line treatments for many conditions. The drugs can be found on the Providence Health Plan formulary.
- Pharmacy Services do not apply to the Out-of-Pocket Maximum.

WEIGHT MANAGEMENT PROGRAM

In 2009, Providence Health Plan partnered with PEBB to provide employees access to a WeightWatchers® program at no cost. The program is available only to employees enrolled in either the full-time employee or part-time employee/retiree medical plan.

The program is offered in three-month segments beginning in January 2010 and available through November 2010. The program offers a variety of options to suit Your needs: Weight Watchers local community groups, online, or through "At Work" groups.

3. HOW TO USE YOUR PLAN

Coverage under this Plan is available 24 hours a day, seven days a week and during periods of domestic or foreign travel.

Coverage under this Plan is provided through:

- The PEBB Statewide Plan Network of Participating Providers located throughout Oregon;
- A national network of Participating Providers, which allows Participants to take advantage of contracted fees when accessing care outside Oregon; **plus**
- Non-Participating Providers.

Coverage Outside the United States

The Plan provides coverage for Medically Necessary Services received outside the United States. You may be required to pay for Services when care is received. It is important that You obtain the most itemized billing possible, and that You ask to have bills written in a foreign language translated into English. If this is not possible, the bills will be translated by Providence Health Plan. Reimbursement for Covered Services received in a foreign country will be based upon the rate of exchange in effect on the date the Services are provided.

Once You have returned to the United States, please forward the bills to Providence Health Plan, attaching a copy of the international claim form. Be sure to include Your group number and member identification number on the form. Claims for all Covered Services must be submitted within one year of the date of Service.

Using Your Plan Coverage

- In most cases, when You use Participating Providers higher benefit levels apply and Your out-of-pocket costs are lower; and
- A wide variety of high-quality Participating Providers is available to help You with Your health care needs.

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

3.1 PARTICIPATING PROVIDERS

Providence Health Plan (PHC) has contractual arrangements with certain physicians/providers, Hospitals and facilities located throughout Oregon. These agreements with PEBB Statewide Plan Participating Providers enable You to receive quality health care for a reasonable cost.

Providence Health Plan’s goal is to maintain Your health by promoting wellness and preventive care. You are encouraged 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.

3.1.1 Nationwide Network of Participating Providers

Providence Health Plan also has contractual arrangements with certain physicians/providers, Hospitals and facilities located outside Oregon. These arrangements allow You to receive Services from Participating Providers even when You are outside Oregon.

3.1.2 Choosing a Participating Provider

To choose a Participating Provider, or to verify if a provider is a Participating Provider, refer to the Provider Directory available online at **www.providence.org/healthplans** under "Search our provider directory."

If You do not have access to the Providence Health Plan Web site, please call Customer Service to request Participating Provider information.

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 3.4.

3.2 THE ROLE OF A PERSONAL PHYSICIAN/PROVIDER

To encourage optimum health, Providence Health Plan promotes wellness and preventive care. Providence Health Plan also believes wellness and overall health is enhanced by working closely with one physician or provider – a Personal Physician/Provider. He or she can provide most of Your care and, when necessary, coordinate care with other providers in a convenient and cost-effective manner. Providence Health Plan recommends that each Participant choose a Participating Personal Physician/Provider as soon as possible.

3.2.1 Personal Physician/Providers

A Personal Physician/Provider is a Qualified Practitioner who specializes in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a physician assistant, when providing Services under the supervision of a physician; who agrees to be responsible for the Participant's continuing medical care by serving as case manager. Adult female Participants 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.

Personal Physicians/Providers provide preventive care and health screening, medical management of many chronic conditions, allergy shots, treatment of some breaks and sprains, 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.

3.3 SERVICES PROVIDED BY NON-PARTICIPATING PROVIDERS

As a PEBB Statewide Plan Participant, 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 Benefit Summary. See section 3.4 for 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, the Plan provides benefits for Medically Necessary Covered Services only when the Services are received from Qualified Practitioners and Qualified Facilities. See section 15 for the definition of Qualified Practitioner and Qualified Facility.

<u>IMPORTANT NOTE</u>: While Providence Health Plan will provide reimbursement for Covered Services received from Non-Participating Providers, **the following Services are covered under Your In-Plan benefit only from Participating Providers**:

- 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); and
- All bariatric surgery Services (see section 6.4).

3.3.1 Indian Health Services Providers

Native American Participants 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 visit the IHS Web site at **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

Note: You are responsible for obtaining Prior Authorization for specified Covered Services received from IHS facilities and providers. See section 3.4.

3.3.2 Sample Benefit Calculation for Non-Participating Providers

If You choose to receive Services from Non-Participating Providers and the Services provided are Medically Necessary Covered Services, the Plan will provide payment 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 that exceed UCR are the Participant's responsibility and are not applied to the Out-Of-Pocket Maximum.

You will be responsible for costs that are not covered or allowed by Your benefits as shown in the following example:

	Provider's Status	
Item	Participating	Non-Participating
Provider's standard charges	$100	$100
Allowable charges under this Group Contract	$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 the provider may bill to You	$-0-	$20 ($100 minus $80)
Total amount You would pay	$16	$44 ($24 plus $20)

3.4 PRIOR AUTHORIZATION

While Prior Authorization is a requirement for coverage of certain Services under this Plan, Prior Authorization is not a treatment directive. The actual course of medical treatment that a Participant chooses remains strictly a matter between the Participant and his/her physician and is separate from the Prior Authorization requirements of this Plan. Further, Prior Authorization is not a guarantee of benefit payment under this Plan, and a Prior Authorization determination does not supersede other specific provisions of this Plan regarding eligibility. Providence Health Plan will only provide Prior Authorization for Medically Necessary Covered Services. If Your Coverage terminates before Services are incurred, the Services will not be covered.

IN-PLAN SERVICES: **Participating Providers are responsible for contacting Providence Health Plan to obtain Prior Authorization.**

OUT-OF-PLAN SERVICES: **You or the Non-Participating Provider must contact Providence Health Plan to obtain Prior Authorization for certain Covered Services. The current list of Covered Services that require Prior Authorization is available from the PHP Customer Service.**

Providence Health Plan will provide a Prior Authorization form upon oral or written request. If You need information on how to obtain Prior Authorization, please call Customer Service at the number listed on Your membership identification card.

If an Emergency Medical Condition exists that prevents You from obtaining Prior Authorization, Providence Health Plan must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, to continue coverage of these Services.

3.4.1 Prior Authorization Requests for Out-of-Network Services:

You or the Non-Participating Provider should call Providence Health Plan at 800-638-0449 to obtain Prior Authorization. When requesting Prior Authorization You will need to furnish the following information:

- Your name;
- Your health plan identification number and group number (these are listed on Your Providence Health Plan Member identification card);
- Your date of birth;
- Provider’s name, address and telephone number;
- The name of the Hospital or treatment facility;
- Scheduled date of admission or date Services are to begin; and
- Treatment or procedure to be performed.

3.4.2 Failure to Obtain Prior Authorization

If You do not obtain Prior Authorization as specified in section 3.4 above, claims for those Services will be denied and You will be responsible to pay for those Services.

3.5 MEDICAL COST MANAGEMENT

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

Providence Health Plan uses protected health information and may share it with others as part of Your treatment, payment for Your treatment, and business operations. Providence Health Plan may share Your information with Your Providers and Hospitals to help them provide medical care to You. For example, if You are in the Hospital,

Providence Health Plan may provide Hospital personnel involved in Your treatment access to any medical records sent to PHP by Your Participating Providers.

Providence Health Plan may use or share Your information with others to help manage Your health care. For example, PHP might talk to Your Participating Provider to suggest a disease management or wellness program that could improve Your health.

The Plan reserves the right to deny payment for Services that are not Medically Necessary in accordance with the criteria maintained by Providence Health Plan. When more than one medically appropriate alternative is available, PHP will approve the least costly alternative.

3.5.1 Coverage of New Technology and New Application of Existing Technology

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 PHP 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.

Providence Health Plan has 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 the 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 that 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.

<u>Technology Evaluation Process</u>

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 that provide independent analysis of a new technology.

<u>Expedited Review</u>

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

3.6 MEDICALLY NECESSARY SERVICES

Providence Health Plan believes Participants are entitled to comprehensive medical care within the standards of good medical practice. Services must be Medically Necessary as defined in section 12 and as determined by PHP medical directors and special committees of Participating Providers. General guidelines for determining whether a Service is Medically Necessary include:

- 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 U.S.. The Plan 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. The Plan 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 cannot pick You up until the next morning. The Plan 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 Providence Health Plan guidelines. Obtaining confirmation of coverage from Providence Health Plan beforehand is always recommended.

3.7 HOW BENEFITS ARE APPLIED

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

1. The Copayment or Coinsurance amount; and
2. The benefit limits and/or maximums.

3.8 OUT-OF-POCKET MAXIMUMS

Your PEBB Statewide Plan has In-Plan Individual and Family Out-of Pocket Maximums as well as Out-of-Plan Individual and Family Out-of-Pocket Maximums.

3.8.1 Understanding Out-of-Pocket Maximums

In-Plan Out-of-Pocket Maximums are the total amount You will pay out-of-pocket in any Calendar Year for Covered Services received using Your In-Plan benefits. Covered Services received from Non-Participating Providers do not apply to the In-Plan Out-of-Pocket Maximums. Your Plan has individual and family In-Plan Out-of-Pocket Maximums.

Out-of-Plan Out-of-Pocket Maximums are the total amount You will pay out-of-pocket in any Calendar Year for Covered Services received using Your Out-of-Plan benefits. Covered Services received from Participating Providers do not apply to the Out-of-Plan Out-of-Pocket Maximums. Your Plan has individual and family Out-of-Plan Out-of-Pocket Maximums.

Separate Accumulation: Your In-Plan and Out-of-Plan Out-of-Pocket 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 calendar year, as shown in the Benefit Summary, before the Plan 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 calendar year, as shown in the Benefit Summary, before the Plan begins to pay 100 percent* for Covered Services for the family. The family Out-of-Pocket Maximum applies when there are more than two Family Members enrolled on this Plan. If three 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 four 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 calendar year.

Note: Once any Participant meets the individual Out-of-Pocket Maximum, the Plan will begin to pay 100%* for Covered Services for that Participant.

The following out-of-pocket costs do not apply toward Your In-plan or Out-of-Plan Out-of-Pocket Maximums:

- Services not covered by this 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 Benefit Summary as not applicable* to the Out-of-Pocket Maximum;
- Copayments or Coinsurance for prescription drugs;
- Copayments or Coinsurance for infertility Covered Service;
- Copayments or Coinsurance for elective termination of pregnancy Services administered through Unified Life;
- Copayments or Coinsurance for chiropractic, acupuncture or naturopathic services; and
- Copayments or Coinsurance for hearing exams or hearing aids.

* Covered Services that are indicated in the Benefit Summary as not applicable to the Out-of-Pocket Maximum are NOT eligible for 100 percent benefits. The Copayment or Coinsurance for those Services that is shown in the Benefit Summary remains in effect throughout the calendar year.

4. ELIGIBILITY AND ENROLLMENT

This section outlines who is eligible for coverage and the related enrollment procedures that apply to Eligible PEBB Members and Eligible Family Dependents. Plan benefits shall not be available to anyone who is not properly enrolled in this Plan.

There will be an Open Enrollment Period each year. The Effective Date of Coverage for new Participants who enroll during the Open Enrollment Period is the beginning of the year for which they enroll.

4.1 PEBB MEMBER ELIGIBILITY AND ENROLLMENT

4.1.1 Eligibility, Effective Date, Enrollment

PEBB Members are eligible for coverage as specified in the eligibility or coverage continuation provisions established by PEBB. The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the PEBB eligibility rules for detailed information on eligibility and program requirements.

4.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

4.2.1 Eligible Family Dependents, Eligibility Date

Eligible Family Dependent means a dependent of a PEBB Member who is eligible for coverage as specified in the eligibility or coverage continuation provisions established by PEBB. The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Participants should refer to the PEBB eligibility rules for detailed information on eligibility and program requirements.

4.2.3 Additional Requirements for Eligible Family Dependent Coverage

1. A PEBB Member may cover Eligible Family Dependents only if the PEBB Member is also covered. Exceptions to this provision apply to COBRA participants and to Retirees who terminate from active coverage.
2. A covered Dependent child who becomes a PEBB Member by virtue of his/her employment is no longer an Eligible Family Dependent.

4.2.4 Eligible Family Dependent Enrollment

You must enroll Eligible Family Dependents in accordance with the requirements established by PEBB. No Eligible Family Dependent will become a Participant until PEBB approves that Eligible Family Dependent for coverage. The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the PEBB eligibility rules for detailed information on eligibility and program requirements.

4.2.5 Newborn Eligibility and Enrollment

A newborn or adopted child of a Participant who meets the definition of an Eligible Family Dependent is eligible for enrollment from the date of birth or placement for the purpose of adoption. The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Participants should refer to the PEBB eligibility rules for detailed information on eligibility and program requirements.

4.3 SPECIAL ENROLLMENT PERIODS

If You declined enrollment for Yourself as a Participant or for an Eligible Family Dependent during a previous enrollment period (as stated in sections 4.1 and 4.2), You may be eligible to enroll Yourself or the Eligible Family Dependent during a "special enrollment period." The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Participants should refer to the PEBB eligibility rules for detailed information on eligibility and program requirements.

4.3.1 New Dependents

If You were eligible to enroll as a Participant in this Plan, but did not enroll during a previous enrollment period, and a person becomes Your Eligible Family Dependent through marriage, birth, adoption or placement for adoption; You may be eligible for a "special enrollment period" during which You and Your Eligible Family Dependent(s) may enroll in any of the medical plan options for which You are eligible. The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the PEBB eligibility rules for detailed information on eligibility and program requirements.

4.4 LEAVE OF ABSENCE AND LAYOFF

The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Participants should refer to the PEBB Summary Plan Description for detailed information on eligibility and program requirements.

5. COVERED SERVICES

This section describes Medically Necessary Services that are covered under this Plan.

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 shown in the Medical Benefit Summary. Covered Services for the diagnosis and treatment of Mental Health or Chemical Dependency are described under Mental Health and Chemical Dependency in sections 5.4 & 5.5.

See section 6 (the Limitations section) for the specific coverage provisions that apply to these Covered Services:

- Human organ/tissue transplants;
- Restoration of head/facial structures and limited dental Services;
- Temporomandibular joint (TMJ) Services;
- Surgery and anesthesia for dental Services;
- Infertility Services; and
- Bariatric surgery Services.

5.1 PROVIDER SERVICES

The following are Covered Services:

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 the Medical Benefit Summary. Copayments and Coinsurances as shown in the Medical Benefit Summary apply to all provider visits except those that: (a) are for conditions for which a separate and specific Copayment or Coinsurance amount is specified in this Member Handbook; or (b) 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 the Medical Benefit Summary. Not all Participating Providers offer E-visits. Medical doctors (M.D.), doctors of osteopathy (D.O.), nurse practitioners (N.P.) and physician assistants (P.A.) 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 to protect Your information from unauthorized access or release.

To be eligible for the E-visit benefit, You must have had at least one prior office visit with Your Participating Provider within the last 12 months.

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

- 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 the Plan;
- Communications by the Participating Provider about the management of complex chronic conditions that require extensive education and ongoing monitoring;
- Communications of treatment for relapses of a previous condition that involve extended dialogue and significant physician time and judgment;
- Discussion of lab results that require significant changes in medication or further testing; and
- 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:

- Renewing prescriptions;
- Scheduling tests;
- Scheduling appointments;
- Reporting normal test results;
- Recommending a referral to another physician;
- A consultative message exchange from a patient who is seen in person immediately afterward as a result of the consultative message;
- A brief follow-up of an office visit, medical procedure or other treatment to confirm stable condition; and
- A brief discussion to confirm stability of a chronic problem and continuity of present management of the problem.
- All communications in connection with mental health or chemical dependency covered services.

5.1.3 Telemedical Services

Medically Necessary Telemedical Services provided by a Qualified Practitioner are covered at the applicable benefit level for the Service, as shown on the Benefit Summary, had the Service been received in person.

5.1.4 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 Medical Benefit Summary.

5.2.1 Physical Examinations and Well-baby Care

Physical examinations and well-baby care for prevention and detection of disease are covered in accordance with the following schedule, or as recommended by Your Qualified Practitioner. In order for a child to be eligible for benefits for routine newborn care, the child must be properly enrolled as outlined in section 4.

Infants up to 24 months	Up to eight well-baby visits
Children	
Two years through six years	One exam every year
Seven years through 19 years	One exam every two years
Adults	
20 years through 29 years	One exam every five years
30 years through 49 years	One exam every two years
50 years and older	One exam every year

Physical Exams for Commercial Drivers License: (limited to the PEBB Member only and only when the exam is required for employment). Coverage is provided for a physical examination required to obtain a commercial driver's license when that examination is performed by a Qualified Practitioner. The PEBB Member must obtain a voucher from PEBB or the employing agency prior to the examination, and the Qualified Practitioner must submit the voucher with the claim.

5.2.2 Immunizations

Benefits for immunizations are provided in accordance with accepted medical practice and as shown in the Medical Benefit Summary. Immunizations received from a Participating Provider or participating pharmacy are covered in full. Providers may bill separately for the office visit associated with administration of the immunization. Immunizations provided by a nonparticipating provider will be subject to any coinsurance shown in the Medical Benefit Summary.

Covered Services do not include immunizations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs or college entrance. Immunizations are covered for the purpose of travel.

5.2.3 Annual Gynecological Examinations

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

5.2.4 Mammograms

Mammograms are covered once age 35 through 40, and once every calendar year for women over 40 years of age, or as recommended by the Personal Physician/Provider or Women's Health Care Provider for women with a designated high risk.

5.2.5 Family Planning Services

Benefits include consultation, IUD insertion and removal, diaphragms, and Depo-Provera to prevent pregnancy. Removal of Norplant is included when determined to be Medically Necessary. Oral contraceptives (birth control pills) are covered and are subject to the terms and limitations of the prescription drug benefits of this Plan.

5.2.6 Prostate Cancer Screening Exams

Benefits for prostate cancer screening examinations include digital rectal examination and prostate-specific antigen test every two years for men age 50 or 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 age 50 or older include:

- One fecal occult blood test per year plus one sigmoidoscopy every five years, or
- One colonoscopy every ten years, or
- One double contrast barium enema every five years.

Exams for Members considered high risk are covered as recommended by the Qualified Practitioner.

5.2.8 Preventive Services for Members with Diabetes

The following Covered Services apply to Participants diagnosed with either insulin dependent or non-insulin dependent diabetes mellitus:

- Annual Exams: Dilated retinal exams by a qualified eye care specialist; glycosylated hemoglobin (HbAlc) test; urine test to test kidney function; blood test for lipid levels as appropriate; visual exam of mouth and teeth by a Qualified Practitioner or other provider (dental visits are not covered); foot inspection; and influenza vaccine.
- Pneumococcal vaccines are provided every five years.

5.2.9 Nutritional Counseling

Nutritional counseling services are covered by the Plan and include Medically Necessary nutritional counseling services related to bariatric surgery, prior to and following the surgery. A maximum of four visits per calendar year are covered for all diagnoses.

5.2.10 Hearing Exams and Hearing Aids

Hearing exams are covered as an office visit, as shown in the Medical Benefit Summary. Hearing aids are covered at 90 percent of allowable expenses or billed charges for non-participating providers, up to a maximum of $4,000 per Member every four calendar years. The coinsurance you pay toward the cost of the hearing aids does not accumulate toward the calendar year Out-of-Pocket maximum.

5.3 HOSPITAL AND SKILLED NURSING FACILITY SERVICES

A Coinsurance will be applied to the allowed charges associated with your Confinement.

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; or
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; and
3. Personal items such as telephone, radio, television and guest meals.

5.3.1 Hospital Services

Benefits are provided as shown in the Medical Benefit Summary 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, oxygen, X-rays, and laboratory services during the period of inpatient hospitalization.

If benefits under this plan change while you or an enrolled dependent is in the Hospital, covered expenses will be based on the benefit in effect when the stay began.

5.3.2 Skilled Nursing Facility

Covered Services from a Skilled Nursing Facility are limited to 180 days per calendar year and are provided as shown in the Medical Benefit Summary. Only Medically Necessary Services are covered and must be Prior Authorized by Providence Health Plan and prescribed by Your Qualified Practitioner. Providence Health Plan may determine that Your care needs are better served by transferring You from a Hospital to a Skilled Nursing Facility and reserves the right to make such a transfer.

5.3.3 Inpatient Rehabilitation Services

Benefits are provided, as shown in the Medical Benefit Summary, for Medically Necessary inpatient rehabilitation to restore or improve lost function following illness or injury. Inpatient rehabilitation Services are limited to 30 days per calendar year. If Services are required following a head or spinal cord injury, or for treatment of a cerebral vascular accident (stroke), the limit may be increased to 60 days per calendar year. If a Participant is hospitalized when rehabilitative Services begin, rehabilitative benefits will begin on the day treatment becomes primarily rehabilitative.

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. Residential Services are limited to 180 days per calendar year.

All inpatient, residential and day or partial hospitalization treatment Services must be Prior Authorized as specified in section 3.4. Contact Providence Health Plan's Mental Health Services Authorized Agent to arrange Prior Authorization (see section 1).

In an emergency situation, go directly to a Hospital emergency room. You do not need Prior Authorization for emergency treatment; however, Providence Health Plan must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, 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. Residential Services are limited to 180 days per calendar year.

All Chemical Dependency Services must:

- 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, be Prior Authorized as specified in section 3.4. Contact Providence Health Plan's Chemical Dependency Services Authorized Agent to arrange Prior Authorization, see section 1.

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, Providence Health Plan must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, for coverage to continue.

5.6 OUTPATIENT HOSPITAL SERVICES, DIALYSIS, CHEMOTHERAPY, RADIATION THERAPY

Benefits are provided as shown in the Other Covered Services section of the Medical Benefit Summary and include outpatient Services at a Hospital or Outpatient Surgical Facility, dialysis, chemotherapy and radiation therapy. See section 5.7.2 regarding injectable medications. Covered Services include, but are not limited to, Services for a surgical procedure and regularly scheduled therapy such as chemotherapy, inhalation therapy, or radiation therapy as ordered by Your Qualified Practitioner.

Covered Services under these benefits do not include Services for short-term outpatient rehabilitation. Please refer to those specific Services within section 5.9.12.

5.6.2 Self-Administered Chemotherapy

Self-administered chemotherapy agents, including oral medications and injectable medications, are covered when received from a participating retail or specialty pharmacy as shown on the Medical Benefit Summary.

Self-administered chemotherapy is covered under Your prescription drug benefit when that coverage results in a lower out-of-pocket expense to You.

5.7 EMERGENCY CARE SERVICES

An Emergency Medical Condition is a 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 birth
- Acute abdominal pain
- Severe chest pain
- Serious burn
- Bleeding that does not stop
- Medically Necessary detoxification

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.

Emergency room Services are covered when Your medical condition meets the guidelines for emergency care as stated above. Covered Services do not include Services for the inappropriate (non-emergency) use of an emergency room. This means Services that could be delayed until You can be seen in Your Qualified Practitioner's office (e.g., treatment of minor illnesses such as flu or sore throat, check-ups, follow-up visits and prescription drug requests).

Benefits for Emergency Services are provided as described below and shown in the Medical Benefit Summary.

5.7.1 Emergency Care

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 48 hours, or as soon as reasonably possible following the onset of treatment, for coverage to continue.

Maternity Services provided for an unexpected delivery outside of the Service Area are covered at the Out-of-Plan level.

Covered Services do **NOT** include Services for the inappropriate (non-emergency) use of an emergency room. This means Services that could be delayed until You can be seen in Your Qualified Practitioner's office (e.g., treatment of minor illnesses such as flu or sore throat, check-ups, follow-up visits and prescription drug requests).

5.7.2 Emergency Medical Transportation

Benefits include Services for emergency medical transportation by state certified ambulance and certified air ambulance transportation when Medically Necessary. Air ambulance transportation must be Prior Authorized by Providence Health Plan except when used for medical emergencies. 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 Providence Health Plan.

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). Participants may receive Services directly from an optometrist or ophthalmologist or a Hospital emergency room.

5.8 URGENT/IMMEDIATE CARE SERVICES

Benefits include Services from an Urgent/Immediate Care facility or other provider and are covered as shown in the Medical Benefit Summary. Urgent/Immediate Care does not include the care of an Emergency Medical Condition.

Urgent/Immediate Care Services are covered for non-life threatening conditions that require immediate attention such as ear, nose and throat infections, and minor sprains and lacerations. Out-of-Plan benefits apply to continuing or follow-up care at the Urgent/Immediate Care facility.

Urgent/Immediate Care Covered Services are provided when Your medical condition meets the guidelines for Urgent/Immediate Care that have been established by Providence Health Plan. Covered Services do not include Services for the inappropriate use of an Urgent/Immediate Care facility, including Services that do not require immediate attention such as routine check-ups, follow-up visits, and prescription drug requests.

5.9 OTHER COVERED SERVICES

The following are other Covered Services and are provided as shown in the Medical Benefit Summary.

5.9.1 Maternity Services and Newborn Nursery Care

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 48 hours for normal vaginal deliveries and 96 hours for cesarean section deliveries, unless the mother and treating physician determine that an earlier discharge is appropriate. See section 5.9.5 for a description of covered diagnostic X-ray and laboratory tests. Maternity Services for a Participant who is serving as a surrogate parent are covered, except to the extent that such Services are payable under the surrogate parenting contract or agreement.

The Plan covers routine nursery care of a well newborn under the newborn’s own coverage. However, this benefit does not cover professional provider charges for well-baby care except as may be specifically provided under other provisions of the plan, nor does it cover pediatric standby charges for a vaginal delivery.

Please note: Benefits for covered expenses of an ill or injured newborn are paid under other provisions of this Plan.

If benefits under this Plan change while you or an enrolled dependent is in the Hospital, covered expenses will be based on the benefit in effect when the stay began.

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 the Medical Benefit Summary. Therapy and testing for treatment of allergies including, but not limited to, Services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment are covered only when such therapy or testing is approved by the American Academy of Allergy and Immunology, or the Department of Health and Human Services or any of its offices or agencies.

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 Medical Benefit Summary based upon the type of Services received. All Covered Services for Reconstructive Surgery must be Prior Authorized. For Reconstructive Surgery of head or facial structures and limited dental Services, see section 6.2

5.9.4 Diabetes Self-Management Education Program

Benefits are paid in full for initial self-management education programs.

5.9.5 Diagnostic Pathology, Radiology Tests and Diagnostic Procedures

Benefits are as shown in the Medical Benefit Summary and include inpatient and outpatient diagnostic pathology (lab), radiology (X-ray) tests and other Medically Necessary diagnostic procedures. Covered Services include contrast materials (dyes) that may be required for a diagnostic procedure.

5.9.6 Home Health Care Benefit

Home health care Services are limited to 180 days per calendar year, are covered as shown in the Medical Benefit Summary and are described below. 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 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 home health care visit. Up to four consecutive hours in a 24-hour period of home health care Service is considered one home health care visit. A home health care visit of more than four hours is considered one visit for every four hours or part thereof.

Home health care will not be reimbursed unless Your Qualified Practitioner certifies that:

1. The home health care Services will be provided or coordinated by a state-licensed or Medicare-certified Home Health Agency or certified rehabilitation agency; and
2. Providence Health Care determines the Services to be Medically Necessary.

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 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 retardation or mental illness, or care of a chronic or congenital condition on a long-term basis.

5.9.7 Hospice Care Benefit

Benefits are included for hospice care as shown in the Medical Benefit Summary and described below. In addition, the following criteria must be met:

1. You obtain Prior Authorization from Providence Health Plan;
2. Providence Health Plan determines the Services to be Medically Necessary;
3. Your Qualified Practitioner certifies that You have a terminal illness with a life expectancy not exceeding six months; and
4. The Covered Services provided are reasonable and necessary for the condition and symptoms being treated.

When the above criteria are met, the Plan will provide benefits for a full range of Covered Services that 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;
7. Continuous home care during a period of crisis in which You require skilled intervention to achieve palliation or management of acute medical symptoms; and
8. Up to 120 hours of respite care.

Services not specified above are excluded from coverage.

5.9.8 Inborn Errors of Metabolism

Benefits are provided for Covered Services as shown in the Medical Benefit Summary based upon the type of Services received for diagnosing, monitoring and controlling inborn errors of metabolism, including phenylketonuria (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.

5.9.9 Medical Supplies and Devices, Prosthetic Devices and Durable Medical Equipment

Benefits for medical supplies/devices, prosthetic devices, and Durable Medical Equipment (DME) are provided as shown in the Medical Benefit Summary when required for the standard treatment of illness or injury. The

purchase of an item may be authorized if Providence Health Plan determines the cost of purchase 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 because of 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 PHP determines otherwise. Repair or replacement is covered if due to normal growth processes or to a change in Your physical condition because of to illness or injury.

Medical Supplies and Devices

Benefits are provided as shown in the Medical Benefit Summary 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 Participants with significant hypoxemia who are unresponsive to other forms of treatment. The benefit is limited to three months from initial date of service unless there is clinical evidence of the need to continue;
4. Orthotics when required as a result of surgery, congenital defect or diabetes. Orthotics do not include prosthetic devices or childhood braces;
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;
6. Diabetes supplies (may be purchased through PHP’s medical supply providers or at participating pharmacies);
7. Medical devices surgically implanted in a body cavity to replace or aid the function of an internal organ; and
8. 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 PHP and in accordance with regulatory requirements.

   Medical Foods are defined as foods that are formulated to be consumed or administered enterally 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 as described in section 5.9.2.

Prosthetic Devices

Benefits are provided for prosthetic devices as shown in the Medical Benefit Summary. Covered Services include prosthetic devices such as artificial limbs, breast implants inserted during reconstructive surgery 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 Medical Benefit Summary. Covered Services include Medically Necessary equipment such as a Hospital bed, non-motorized wheelchair, ventilator and similar equipment as approved by PHP.

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).

5.9.10 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 Medical Benefit Summary. Covered Services do not include routine foot care and the removal of corns or calluses, unless You have diabetes.

5.9.11 Reconstructive Breast Surgery

Benefits for Reconstructive Surgery of the breast are covered as those Services listed in the Medical Benefit Summary based upon the type of Services received and in accordance with the Women's Health and Cancer Rights Act of 1998. 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.

5.9.12 Short-Term Outpatient Rehabilitation

Short-term outpatient rehabilitation Services are limited to 60 visits per calendar year. 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 Medical Benefit Summary, to restore or improve lost function following illness or injury. Rehabilitative services also include neurodevelopmental therapy for children up to age 18 when such services are for maintenance of a child whose condition would otherwise significantly deteriorate without the services. Benefits are limited to Covered Services that can be expected to result in measurable improvement of a Participant's condition.

IMPORTANT NOTE: A visit is considered a treatment with one provider. For example, if a physical therapist and a speech therapist are seen on the same day at the same facility, the services will count as two visits, as treatment has been received from two providers.

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

1. Adjustments and manipulations of any spinal or bodily area, except as covered under the alternative care benefit described in section 5.9.13;
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 5.9.6.

5.9.13 Alternative Care

Medically Necessary Services from the following alternative care providers are covered as shown in the Medical Benefit Summary. Participants may access Covered Services from any Acupuncturist, Chiropractor or Naturopathic Physician that is licensed in the state in which they are practicing, and practicing within the scope of their license.

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

Acupuncture Care 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.

Chiropractic Care Services

Covered Services from chiropractors:

- Office visits.
- Manipulation of the spine, joints or musculoskeletal soft tissue, a re-evaluation, 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 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, or musculoskeletal soft tissues.
- Clinical laboratory studies performed in a chiropractor's office.
- Venipuncture.

Naturopathic Care Services

Naturopathic physician Services are examination, clinical laboratory, diagnostic x-ray, office visit, consultation, 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.

Covered Services from naturopathic physicians:

- Office visits and 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 or 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

General Exclusions to Alternative Care Services

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.
- Thermography.
- Therapeutic modalities and procedures that are considered by PHP 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 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.

5.9.14 Elective Sterilization Services

Coverage is provided, as shown in the Medical Benefit Summary, for voluntary sterilization (vasectomy or tubal ligation). Services to reverse a prior sterilization procedure are not covered.

5.9.15 Termination of Pregnancy Services

Covered Services include elective termination of pregnancy. Claims are processed under a separate administrative agreement with Unified Life Insurance Company, as shown in section 8.

5.9.16 Tobacco Cessation Services

Participation in the Free & Clear® tobacco cessation program is covered in full. This program addresses tobacco dependence through a clinically proven, comprehensive approach to tobacco cessation that treats all three aspects

of tobacco use – physical addiction, psychological dependence and behavioral patterns. An expert Quit Coach will create a quit plan for each program participant that includes:

- One-on-one phone based treatment sessions;
- Unlimited toll-free telephone access to Quit Coaches;
- A Quit Kit of materials designed to help program participants quit tobacco use through active self-management;
- Recommendations on and direct fulfillment of nicotine replacement therapy, if appropriate; and
- Information and decision support for bupropion or Chantix, if appropriate.

Free & Clear®can be reached at 1-866-QUIT-4-LIFE (784-8454), 5 a.m. through 9 p.m. (Pacific Time), seven days a week.

5.10 PRESCRIPTION DRUG BENEFITS

The prescription drug benefits that are available under this Plan are described in this section and in the Prescription Drug Summary of Benefits. All Covered Services are subject to the specific conditions, duration limitations and all applicable maximums that are specified in this Member Handbook.

This Plan will provide benefits for prescription drugs that are Medically Necessary for the treatment of a covered illness or injury and that are dispensed by a participating pharmacy pursuant to a prescription ordered by a Qualified Practitioner for use on an outpatient basis. Participating pharmacies are those pharmacies that maintain all applicable certifications and licenses necessary under state and federal law of the U.S. and have an agreement with PHP to provide prescription drug benefits. PHP has approximately 22,000 participating pharmacies available for Your use nationwide.

5.10.1 Using Your Prescription Drug Benefits

- You must access prescription drug Services through Participating Providers and participating pharmacies. You may obtain a list of Providence Health Care's participating pharmacies from their Web site at **www.providence.org/healthplans** or by contacting PHP Customer Service at the telephone number listed on Your Membership Identification Card (ID Card).
- All Covered Services are subject to the Copayments or Coinsurance amounts and benefit maximums shown in the Prescription Drug Summary of Benefits. Copayments or Coinsurance amounts for prescription drug Covered Services do not apply to the Participant's medical annual Out-of-Pocket Maximum and are due at the time of purchase. Participating pharmacies may not charge You more than Your Copayment or Coinsurance. Please contact Customer Service if You are asked to pay more or if You or the pharmacy have questions about Your prescription drug benefits or need assistance processing Your prescription.
- If you are covered under this Plan and another pharmacy plan administered by PHP, the participating pharmacy will automatically coordinate coverage. You will need to present your primary insurance card to the pharmacy before filling the prescription and notify Customer Service of the other coverage so it can be documented in your file. If your other pharmacy coverage is not administered by PHP, you will need to submit a claim form for reimbursement. Please contact Customer Service to if You or the pharmacy have questions.
- Some drugs require Prior Authorization for Medical Necessity, length of therapy, step therapy, number of doses or dispensing limits. PHP's prescription drug formulary indicates those medications that require Prior Authorization; the formulary is available from Customer Service and from the PHP Web site at: **http://www.providence.org/healthplans/members/pharmacy/default.aspx**
- You may purchase up to a 90-day supply of each maintenance drug at one time using a participating mail service pharmacy, as described under the Participating Mail Order Pharmacy section or a Preferred Retail Pharmacy. Not all prescription drugs are available through the mail order pharmacies.
- Diabetes supplies and inhalation extender devices may be obtained at a participating pharmacy. However, such items are considered medical supplies and devices and are covered under the benefit provisions of section 5.7.9 rather than the prescription drug provisions of this section.

- 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 PHP's designated Specialty Pharmacy. Due to the nature of these medications, they are not considered "maintenance" drugs and are limited to a 30-day supply (or minimum package size to approximate a 30-day supply). Specialty drugs are indicated on the Providence Health Plan formulary as "specialty" in the status column. View the formulary by visiting the PHP Web site, **www.providence.org/healthplans** or call Customer Service.
- You must present Your ID Card to the participating pharmacy at the time You request Services. Your use of the ID Card for prescription drugs helps streamline pharmacy costs and eliminates extra work for You, the pharmacist and PHP. If You have misplaced Your ID Card or don't have Your ID Card with You when You need to purchase prescription drugs, please ask Your pharmacist to call PHP.

5.10.2 Using 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. You may be reimbursed by the Plan upon submission of a Prescription Drug Reimbursement form, which can be obtained from the PHP Web site or by contacting Customer Service. You must include any itemized pharmacy receipts along with this form. You will also need to provide an explanation as to why You used a non-participating pharmacy. Once received, Your claim will be reviewed (submission of a claim does not guarantee payment). If Your claim is approved, PHP will reimburse You the cost of Your prescription up to the participating pharmacy contracted rates, subject to the terms of this Plan and the Prescription Drug Summary of Benefits, less Your applicable Copayment or Coinsurance. You are responsible for any amounts above PHP's contracted rates.

5.10.3 Prescription Drug Formulary

A prescription drug formulary means a list of drugs, current clinical drug information, therapeutic approach to disease and comparative cost information to be used as a reference by prescribing physicians.

Providence Health Plan maintains a closely managed, open formulary. Formulary status is given to drugs that meet evidence-based assessment of therapeutic effectiveness, safety, and pharmacoeconomic value and offer an important advantage to existing formulary alternatives.

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 the plan. Newly approved drugs will be reviewed for safety and medical necessity by PHP's Pharmacy & Therapeutics Committee within 12 months following FDA-approval. In an urgent situation, PHP will authorize the use of a newly approved FDA drug during the review period so a Participant does not go without Medically Necessary treatment.

PHP's formulary is updated regularly throughout the year, and Qualified Practitioners are encouraged to submit suggestions for additions to PHP. You may obtain a copy of the formulary from the PHP Web site or by contacting Customer Service.

5.10.4 Generic and Brand Name Prescription Drugs

Both generic and brand names drugs are covered as specified in this section. In general, generic drugs are subject to lower Copayments or Coinsurance amounts than brand name drugs. Please refer to the Prescription Drug Summary of Benefits for Your Copayment or Coinsurance information.

Generic medication means a prescription medication that is:

- An **equivalent medication** to the **brand name medication**;
- Marketed as a therapeutically equivalent and interchangeable product; and
- Listed in widely accepted references as a **generic medication** and specified as a **generic medication** under the terms of this Plan.

Equivalent medication means the US Food and Drug Administration (FDA) ensures that the **generic medication** must:

- Have the same active ingredients;
- Meet the same manufacturing and testing standards; and
- Be absorbed into the bloodstream at the same rate and same total amount as the **brand name medication**.

These requirements ensure that the generic medication has the same effectiveness as the brand name medication. If listings in widely accepted references are conflicting or indefinite about whether a prescription medication is a generic or brand medication, PHP will determine whether the prescription medication is a generic or brand name medication.

Brand name medication (**single source brand**) means a prescription medication that has a current patent and is marketed and sold by limited sources or is listed in widely accepted references as a brand name medication based on manufacturer and price.

Multi-source brand name medication means a brand name medication for which a **generic medication** may be substituted under the laws and regulations of the state in which the pharmacy dispensing the prescription is located.

Exception Process:

An exception process is available if the prescribing provider believes that it is medically necessary for You to use a non-preferred (non-formulary) brand name drug instead of a preferred (formulary) brand name or generic drug. A request for medical exception that explains why the drug substitution is medically appropriate may be submitted by Your provider to PHP. If the request is approved, the benefits for **preferred** (formulary) brand name drugs will apply. If the request is denied, the appeal rights described in section 9 will apply.

If You request, or Your physician prescribes, a nonpreferred (non-formulary) brand name drug when a generic equivalent is available, You will be responsible for the difference in cost between the brand name drug and the generic drug, in addition to the brand Copayment or Coinsurance. The total cost, however, will never exceed the cost of the drug.

5.10.5 Prescription Quantity

Prescription dispensing limits, including refills, are as follows: 1) topicals, up to 60 grams; 2) liquids, up to eight ounces; 3) tablets or capsules, up to 100 dosage units; and 4) multi-use or unit-of-use, up to one container or package; as prescribed, not to exceed a 30 consecutive day supply, whichever is less. Other dispensing limits may apply to certain medications requiring limited use, as determined by PHP's medical policy. Prior Authorization is required for amounts exceeding any applicable medication dispensing limits.

5.10.6 Participating Mail Order Pharmacy

Prescribed maintenance drugs (pharmaceutical products that for the majority of patients are prescribed in a constant, on-going manner) purchased from a participating mail order pharmacy will be covered subject to the following specific provisions:

1. Qualified drugs under this program will be determined by PHP. Not all drugs are available through mail order pharmacy.
2. Copayment(s) will be applied to the quantity stated in the Prescription Drug Summary of Benefits.

Payment is required prior to processing Your order. If there is a change in PHP's participating mail service pharmacies, You will be notified of the change at least 30 days in advance.

To purchase prescriptions by mail, Your physician or provider can call in the prescription, or You can mail Your prescription along with a notation of Your PHP ID number to a participating mail order pharmacy. Participating

mail order information is available on the PHP Web site at **www.providence.org/healthplans**. Please note that you may also purchase up to a 90-day supply of medication at preferred retail pharmacies.

5.10.7 Prescription Drug Limitations

Prescription drug limitations are as follows:

1. Medications, drugs, or hormones prescribed to stimulate growth are not covered except when there is a laboratory confirmed diagnosis of growth hormone deficiency for children through 18 years of age and when prescribed for the treatment of documented pituitary destruction in adults; and
2. Compound prescription drugs must contain at least one ingredient that is an FDA-approved prescription drug in a therapeutic amount, must meet PHP's medical necessity criteria and be purchased at a participating pharmacy. Compounded drugs from bulk powders that are not a component of an FDA-approved drug are not covered.
3. Specialty medications are limited to a 30-day supply (or minimum package size to approximate a 30-day supply). These drugs must be purchased through PHP's designated specialty pharmacy.

5.10.8 Prescription Drug Exclusions

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

1. Drugs or medicines delivered, injected, or **administered to You by a physician or other provider**;
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 the Medical Summary of Benefits.);
6. **Experimental** or **investigational** drugs or drugs used by a Participant in a research study or in another similar investigational environment;
7. **Fluoride**, for Participants over the age of 10 years old;
8. Drugs that are not provided in accordance with the PHP's **formulary** management program, unless approved in the exception process;
9. Drugs used in the treatment of **fungal** nail conditions;
10. Drugs to stimulate **Hair Growth,** including, but not limited to **Rogaine** (topical minoxidil) or other similar drug preparations;
11. **Injectable medications** unless they are: intended for self-administration; labeled by the FDA for self-administration and purchased through Providence Health Plan's designated specialty pharmacy.
12. **Intrauterine devices** (IUDs), diaphragms and implantable contraceptives. (Some of these items may be covered under Your medical benefits. Please refer to the Medical Summary of Benefits.);
13. Drugs or medications prescribed that are not **Medically Necessary** or are not provided according to the PHP's medical policy or Prior Authorization requirements;
14. **Methadone** is covered for pain management but is excluded for the treatment of chemical dependency. Methadone to treat chemical dependency is covered under the medical chemical dependency benefit when the treatment is part of an approved medically supervised treatment program and is subject to any applicable benefit limits;

15. **Over-the-Counter (OTC) drugs, medications** or **vitamins**, that may be purchased without a provider's written prescription;
16. **P**rescription drugs for which there are OTC therapeutically similar forms;
17. Drugs dispensed from **pharmacies outside the United States**, except when prescribed for Urgent/Immediate Care and Emergency Medical Conditions;
18. Drugs which, by law, do not require a **prescription**, except insulin;
19. **Replacement of lost** or stolen medication;
20. 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;
21. Drugs dispensed or compounded by a pharmacist that do not have at least one FDA approved medication in **therapeutic amount**;
22. Drugs used for **weight loss** or for **cosmetic** purposes;
23. Drugs used in the treatment of drug induced fatigue, general fatigue and idiopathic hypersomnia;
24. Drugs placed on prescription-only status as required state or local law (i.e., OTC drugs such as Sudafed); and
25. Drugs that are not approved by the Food and Drug Administration (FDA) or designated as "less than effective" by the FDA, also known as "DESI" drugs.

5.10.9 Prescription Drug Disclaimer

The Plan and Providence Health Plan 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 Plan.

6. LIMITATIONS FOR SPECIFIED COVERED SERVICES

There are limitations on the benefits available under this 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 Participant); or
- Removed from and replaced in the same person's body (a self-donor who is a Participant).

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 (see also the Exclusion Period in section 6.1.7)

Covered Services for transplants are limited to Services that:

1. Are Prior Authorized and determined by PHP to be Medically Necessary and medically appropriate according to national standards of care;
2. Are provided at a facility approved by PHP or under contract with PHP **(Transplant Services are not covered Out-of-Plan)**;
3. Involve one 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.

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 30 consecutive days following that surgery.

6.1.2 Benefits for Donor Costs

Benefits for donor or self-donor costs are payable as long as the transplant recipient is a Participant under this Plan.

6.1.3 Benefits for Transplant Facility Services Provided to the Organ Recipient

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

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

6.1.4 Benefits for Outpatient Medications

Outpatient prescription medications for transplant-related Services, including anti-rejection (immunosuppressive) drugs, are covered under the outpatient prescription drug benefits of this Plan, as specified in section 5.10.

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

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

6.1.6 Prior Authorization (see also section 3.4)

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

- Initial consultation;
- Evaluation;
- Transplant facilities;
- Donor evaluation;
- Donor Services;
- HLA typing;
- Travel expenses;
- Pre-transplant care;
- Self-donation Services;
- Transplant Services; and
- Follow-up treatment.

6.1.7 Exclusion Period

No benefits for human organ/tissue transplant Covered Services will be payable during the first 24 months that a Participant is covered under this Plan unless:

1. The Participant has been continuously covered under Creditable Coverage since birth or placement for adoption; or
2. The Participant has applicable Creditable Coverage. The duration of the 24-month Exclusion Period will be reduced by the amount of the Participant's prior Creditable Coverage if the most recent period of Creditable Coverage ended within 63 days of the Effective Date of Coverage under this Plan. However, Creditable Coverage will only be applied to human organ/tissue transplant Covered Services that were specified as covered under the prior Creditable Coverage, regardless of the level of such prior coverage or the Participant's use of such prior coverage. The Participant is responsible for furnishing proof of Creditable Coverage and evidence of the terms of human organ/tissue transplant benefits under the previous coverage.

6.1.8 Exclusions

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

- Any transplant procedure that has not been Prior Authorized;
- Any transplant procedure performed at a transplant facility that has not been approved by PHP;
- Any transplant that is Experimental/Investigational, as determined by PHP;
- Services or supplies for any transplant that are not specified as Covered Services in this section 6.1, such as transplantation of animal organs or artificial organs;
- High-dose chemotherapy administered prior to a transplant, unless those Services have been Prior Authorized;
- Services related to organ/tissue donation by a Participant if the recipient is not a Participant or the Participant/recipient is not eligible for transplant benefits under this Plan; and
- Transplant-related travel expenses for the donor and the donor's and recipient's family members.

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 development deformities, not including malocclusion of the jaw, 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 Medical Benefit Summary based upon the type of Services received.

Limitations that apply to Covered Services include:

- All treatment, except Emergency Services must be Prior Authorized; and
- Conditions related to trauma must be diagnosed within six months of injury, and treatment must begin within 12 months of the injury.

Exclusions that apply to Covered 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 the following section of this Member Handbook.

6.2.1 Temporomandibular Joint (TMJ) Services

Benefits are provided for TMJ Services from a Participating Provider as shown in the Medical Benefit Summary. All Covered Services for TMJ must be Prior Authorized. 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 5.9.9 (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 Medical Benefit Summary based upon the type of Services received. Services must be Prior Authorized and will only be provided for Participants 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 that cannot be managed safely and efficiently in a dental office.

Dental Services are excluded.

6.3 INFERTILITY SERVICES

Coverage for infertility Services is provided, as shown in the Medical Benefit Summary, when a diagnosis of infertility has been established. Infertility is defined as the inability to become pregnant after one year of unprotected intercourse with a partner of the opposite sex or the inability to carry a pregnancy to term as evidenced by three consecutive spontaneous miscarriages.

Covered Services include the following:

1. Diagnostic testing and associated office visits to determine the cause of infertility. This includes the physical examination, related laboratory testing, instruction, and medical/surgical procedures when preformed for the sole purpose of diagnosing and treating an infertile state. Diagnostic Services for the treatment of infertility include, but are not limited to hysterosalpingogram, laparoscopy, and pelvic ultrasound;
2. Artificial insemination, limited to maximum of six cycles and sperm wash;
3. Cost of acquiring semen;
4. Infertility related drugs or injectables; and
5. Covered infertility-related supplies.

Covered Services do NOT include:

1. Charges for donor semen from donor banks or other providers;
2. Charges for harvesting and storage of semen other than for immediate use;
3. Infertility Services not resulting from a medical condition;
4. All Services for non-Participant surrogate mothers; and
5. Infertility resulting from the aging process as confirmed by elevated follicle stimulating hormone (FSH).
6. In vitro and in vivo fertilization including services related to or supporting in vitro fertilization, GIFT, ZIFT, reversals of voluntary sterilization and procedures determined to be experimental or investigational.

Expenses for infertility Services do not accumulate toward the calendar year out-of-pocket maximum.

6.4 BARIATRIC SURGERY

In-Plan coverage for bariatric/gastric bypass surgery Services for morbid obesity is provided, as shown in the Medical Benefit Summary for inpatient Services, in accordance with the medical policy and criteria established and maintained by PEBB. Prior Authorization is required for coverage of bariatric/gastric bypass surgery Services. Approved surgical procedures may include gastric bypass, gastric stapling, gastroplasty, and the Lap-Band adjustable gastric banding system. Services must be received at a Medicare-approved facility. To locate a Medicare-approved facility, visit the Centers for Medicare & Medicaid Services (CMS) Web site at http://www.cms.hhs.gov/MedicareApprovedFacilitie/ and select Bariatric Surgery.

The PEBB criteria require an extensive evaluation prior to surgery and a staged approach:

Stage 1 – Patient meets clinical criteria necessary to be selected for Stage 2:

- BMI equal to or greater than 35 with a diagnosis of diabetes; or BMI equal to or greater than 40 with any comorbid condition; or BMI equal to or greater than 50 with or without comorbid conditions.

Stage 2 – Patient completes a 6-month work up that includes: (patient may meet work up requirements in less than six months)

- Dietary counseling and education;
- Medical and psychological evaluation; and
- A weight loss of greater than 5% during the 6-month work up period.

Stage 3 – Patient completes the final stage including:

- Compliance with Stage 2 and approval to proceed; and
- Surgery done in a Center of Excellence based on program criteria.

Program Selection Guidelines: The following guidelines are designed to limit mortality and morbidity and are based on those of local health plans and the American Society of Bariatric Surgery:

- Established bariatric surgery program with 5 years' experience and supervised by a Board certified surgeon.
- Significant patient morbidity must be less than 20%.
- Performed at least 100 bariatric procedures over the last 5 years.
- Overall mortality rate must be less than 2%.
- Average documented follow-up of patients must be greater than 5 years.
- Significant weight loss demonstrated in 75% of all patients over 5 years.
- Average of 30% excess body weight loss achieved and maintained.

7. EXCLUSIONS

In addition to those Services listed as not covered in the Covered Services or Limitations sections, the following are specifically excluded from coverage under this Plan.

General Exclusions:

The Plan does 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 received after Coverage terminates;
- 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 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, domestic partner, 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 Plan;
- Are provided for any injury or illness that is sustained by a PEBB Member 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 PEBB Member 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 Participants 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 Plan that are subject to this exclusion are provided solely to assist You, and such assistance does not waive the Plan's right to reimbursement or subrogation as specified in section 8.2. This exclusion also applies to Services and supplies after You have received proceeds from a settlement as specified in section 8.2.3;
- 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 that is not Medically Necessary;
- Are Experimental/Investigational;
- Are determined by Providence Health Plan not to be Medically Necessary for diagnosis and treatment of an injury or illness;
- Relate to any condition determined by PHP to have been sustained as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Participant requiring Services, whether or not such Participant is charged or convicted of a crime on account of such illegal engagement or act (for purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony or misdemeanor under applicable law if such Participant were convicted for the conduct). Nothing in this paragraph shall be construed to exclude Covered Services for a Participant 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 that are specified as excluded in section 15 in the definitions of 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 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 5.9.12;
- 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 brain scans (except as provided in section 5.9.5);
- 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;
- Treatments that do not meet the national standards for Mental Health/Chemical Dependency professional practice; and
- Residential mental health or chemical dependency Services in excess of 180 days per calendar year.

Exclusions that apply to Provider Services:

- The following Services if they are provided by a Non-Participating Provider:
  - All Human Organ/Tissue Transplants (see section 6.1);
  - All E-visit Services (see section 5.1.2);
  - Bariatric Surgery and related services (see section 6.4); and
- Services of homeopaths or faith healers; and
- Services of 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;
- Condoms and other over-the-counter birth control products; and
- Home births and all related Services, except Services provided by a Qualified Provider.

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 keratomelelusis 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 exams and vision care, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in section 5.9.9; and
- Orthoptics and vision training.

Exclusions that apply to Dental Services:

- Oral surgery (non-dental or dental) or other dental Services (all procedures involving the teeth, wisdom teeth, and areas surrounding the teeth), except as approved by Providence Health Plan and described in the Limitations section;
- Services for temporomandibular joint syndrome (TMJ) and orthognathic surgery, except as approved by Providence Health Plan and described in the Limitations section;
- Procedures to treat or correct malocclusion of the jaw; and
- Dentures and orthodontia.

Exclusions that apply to Foot Care Services:

- Routine foot care, such as removal of corns and calluses, except for Participants with diabetes; and
- Services for insoles, arch supports, heel wedges, lifts and orthopedic shoes. Covered Services for orthotics are described within the Covered Services section under Medical Supplies/Devices.

Exclusions that apply to Prescription Drugs, Medicines and Devices:

- Any drug, medicine, or device that does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Pre-market Approval, or 510K.

Exclusions that apply to Miscellaneous Services and Items:

- Custodial Care;
- Transplants, except as described in the Limitations sections;
- Services for Durable Medical Equipment (DME), medical supplies/devices and prosthetic devices except as described in the Other Covered Services section;
- 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 section 5.3.3 and 5.7.12;
- “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;
- Non-emergency medical transportation;
- Allergy shots and allergy serums, except as provided in section 5.7.2;

- Services for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas;
- Transportation or travel time, food, lodging accommodations and communication expenses except as provided in section 6.1 and with Providence Health Plan's Prior Authorization;
- 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 for Cosmetic Services including supplies and drugs, except as approved by Providence Health Plan and described in the Covered Services section;
- Services related to obtaining insurance, employment, licensure (except as specified in section 5.2.1) or school admission; Services solely for the purpose of participating in camps, sports activities or recreation programs; Services 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; and
- Air ambulance transportation for non-emergency situations unless Prior Authorized by Providence Health Plan.
- Charges for missed appointments.

8. CLAIMS ADMINISTRATION

8.1 SUBMITTING CLAIMS

All Participating Providers and many Non-Participating Providers will bill Providence Health Plan for You. You may receive a bill for information purposes only indicating your insurance was billed. To ensure the timely processing of claims please submit a claim for treatment within 60 days of the date of service. The Plan will not pay claims received more than 12 months after the date of service. However, exceptions will be made if the Plan receives documentation of Your legal incapacitation. The Plan will pay a covered expense to the provider, the Participant, or jointly to both. If the Plan mistakenly makes a payment to which a Participant is not entitled, the Plan may recover the payment.

Claims should be submitted to Providence Health Plan at:
Providence Health Plan
P.O. Box 4447
Portland, OR 97208-4447
For claim questions, please call: 503-547-7500 (Portland area), 1-800-878-4445 (toll-free),
503-574-8702 (TTY Portland area), 1-888-244-6642 (TTY toll-free).

Claims for elective termination of pregnancy Services should be submitted to:
Unified Life Insurance Company
Attention: Claims
P.O. Box 530128
Livonia, MI 48153-0128
1-800-342-2641 (6AM – 4:30PM Pacific time)

Explanation of Benefits (EOB). You will receive an EOB from Providence Health Plan after Your claim is processed. An EOB is not a bill. An EOB explains how Providence Health Plan has processed Your claim and it will assist you in determining Your financial responsibility for the services shown on the EOB. Copayment and Coinsurance amounts, services or amounts not covered and general information about PHP's processing of Your claim are explained on the EOB.

Plan Time Frames for Processing Claims. If Your claim is denied under the Plan, Providence Health Plan will send an EOB to You with an explanation of the denial within 30 days after Your claim is received. If Providence Health Plan needs additional time to process Your claim for reasons beyond its control, You will be sent a notice of delay explaining those reasons within 30 days after Your claim is received. PHP will then complete the processing and send an EOB to You within 45 days after Your claim is received. If Providence Health Plan needs additional information from You to complete the processing of Your claim, the notice of delay will describe the information needed and You will have 45 days to submit the additional information. Once PHP receives the additional information, it will complete the processing of the claim within 15 days.

Claims Involving Prior Authorization (Pre-Service Claims)

- **For services that do not involve urgent medical conditions**: Providence Health Plan will notify Your provider or You of its decision within two business days after the Prior Authorization request is received. If PHP needs additional time to process the request for reasons beyond its control, it will complete its review and notify Your provider or You of its decision within seven days after receipt of the request.
- **For services that involve urgent medical conditions**: Providence Health Plan will notify Your provider or You of its decision within 24 hours after the Prior Authorization request is received. If PHP needs additional information to complete its review, it will notify the requesting provider or You within 24 hours after the request is received. The requesting provider or You will then have 48 hours to submit the additional information. PHP will then complete its review and notify the requesting provider or You of its decision by the earlier of, (a) 48 hours after the additional information is received or, (b) if no additional information is provided, 48 hours after the additional information was due.

Claims Involving Concurrent Care Decisions. If an ongoing course of treatment for You has been approved by Providence Health Plan and it then determines through its medical cost management procedures to reduce or terminate that course of treatment, You will be provided with advance notice of that decision. You may request a reconsideration of that decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. PHP will then notify You of its reconsideration decision within 24 hours after Your request is received.

8.1.1 Right of Recovery

Providence Health Plan, on behalf of the Plan, has the right, upon demand, to recover payments in excess of the maximum benefits specified in this Plan or payments obtained through fraud, error, or duplicate coverage. If reimbursement is not made to the Plan, Providence Health Plan is authorized by PEBB to deduct the overpayment from future benefit payments under this Plan. Providence Health Plan, on behalf of the Plan, has the right to recover pharmacy over payments directly from You or Your Family Member.

8.2 THIRD-PARTY LIABILITY/SUBROGATION

The following provisions will apply when You have received Services for a condition for which one or more third parties may be responsible. "Third party" means any person other than You and PEBB, as the sponsor of this Plan, and includes any insurance carrier providing liability or other coverage potentially available to You. For example, uninsured or underinsured motorist coverage, no-fault medical payments (auto, homeowners or otherwise), or other insurance (including student plans) whether under Your policy or not, is subject to recovery by Providence Health Plan as a third-party recovery. Failure by You to comply with the terms of this section will be a basis for Providence Health Plan to deny any claims for benefits arising from the condition. In addition, You must execute and deliver to Providence Health Plan or other parties any document requested which may be appropriate to secure the rights and obligations of You and the Plan under these provisions.

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

Third-party liability refers to claims that are in whole or in part the responsibility of someone besides this Plan or You. Examples of third-party liability are motor vehicle accidents, workplace injury or illness, or any other situation involving injury or illness, including wrongful death, in which You or Your heirs, beneficiaries, or relatives have a basis to bring a lawsuit or to make a claim for compensation against any person or for which You or Your heirs, beneficiaries, or relatives may receive a settlement (for example, food poisoning or an injury from a defective product are examples of third-party liability). 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, The Plan 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 Plan.

If Providence Health Plan makes claim payments on Your behalf for which a third party is responsible, the Plan is 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 Providence Health Plan may collect directly from the third party to the extent that the Plan has paid on Your behalf for third-party liabilities. Because the Plan has paid for Your injuries, the Plan, rather than You, is entitled to recover those expenses. Prior to accepting any settlement of Your claims against a third party, you must notify PHP in writing of any terms or conditions offered in settlement and must notify the third party of the Plan's interest in the settlement established by this provision.

To the maximum extent permitted by law, the Plan is subrogated to Your rights against any third party who is responsible for the condition, has the right to sue any such third party in Your name, and has a security interest in and lien upon any recovery to the extent of the amount of benefits paid by the Plan and for Providence Health Plan's expenses in obtaining a recovery. If You should either decline to pursue a claim against a third party that

Providence Health Plan believes is warranted or refuse to cooperate with PHP in any third party claim that you do pursue, PHP has the right, on behalf of the Plan, to pursue such claim directly, including commencing a legal action against such third party or intervening in any action that You have commenced.

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

8.2.2 Proceeds of Settlement or Recovery

If for any reason Providence Health Plan is not paid directly by the third party, PHP is entitled to reimbursement from You or Your heirs, legal representatives, beneficiaries or relatives, and may request refunds from the medical providers who treated You, in which case those providers will bill You for their Services. To the fullest extent permitted by law, the Plan is entitled to the proceeds of any settlement or any judgment that results in a 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 the Plan and whether or not You are alleged to have any fault, under principles of comparative negligence or otherwise. With respect to any workers' compensation recovery, the Plan is entitled to the proceeds whether or not the loss is deemed to be compensable under the worker's compensation laws. The Plan is entitled up to the full value of the benefits provided by it for the condition, calculated using Providence Health Plan's UCR charges for such Services, less the Participant's out-of-pocket expenses and attorney fees incurred in making the recovery. The Plan is entitled to such recovery regardless of whether You have been fully compensated or "made whole" for the loss caused by the third party, and regardless of whether You have been partially compensated for such loss. The Plan is entitled to first priority in repayment, over You and over any other person, for such charges.

By accepting benefits under this Plan, You acknowledge the Plan's first priority to this repayment and assign to the Plan any benefits You may have from other sources. You must cooperate fully with Providence Health Plan in recovering amounts paid by the Plan. If You seek damages against the third party for the condition and retain an attorney or other agent for representation in the matter, You agree to require Your attorney or agent to reimburse the Plan directly from the settlement or recovery in the amount provided by this section.

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

8.2.3 Suspension of Benefits and Reimbursement

After You have received proceeds of a settlement or recovery from the third party, You are responsible for payment of all medical expenses for the continuing treatment of the illness or injury that the Plan would otherwise be required to pay until all proceeds from the settlement or recovery have been exhausted. If You have failed to reimburse the Plan as required by this section, the Plan is entitled to offset future benefit otherwise payable under the Plan or under any future Plan sponsored by PEBB, to the extent of the value of the benefits advanced under this section.

If You continue to receive medical treatment for the condition after obtaining a settlement or recovery from one or more third parties, the Plan is not required to provide coverage for continuing treatment until You prove to

Providence Health Plan's 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. The Plan will cover only the amount by which the total cost of benefits that would otherwise be covered under this Plan, calculated using Providence Health Plan's UCR charges for such services, exceeds the amount received in settlement or recovery from the third party. The Plan is entitled to suspend such benefits even if the total amount of such settlement or recovery does not fully compensate You for other damages, particularly including lost wages or pain and suffering.

Any settlement arising out of an injury or illness covered by this Plan will be deemed first to compensate You for Your medical expenses, regardless of any allocation of proceeds in any settlement document that Providence Health Plan has not approved in advance. In no event shall the amount reimbursed to the Plan be less than the maximum permitted by law.

8.3 COORDINATION OF BENEFITS (COB)

This Coordination of Benefits (COB) section applies when You or a Family 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.

If You have more than one insurance plan, obtaining Services under this Plan may be affected. Please contact Customer Service for more information or assistance.

8.3.1 Definitions Relating to Coordination of Benefits

Plan

Plan means any of the following that provides benefits or Services for medical or dental care 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

As used in this COB section, This Plan means the part of the plan benefits to which this COB section applies and which may be reduced because of benefits provided by other plans. Any other part of This Plan providing health care benefits is separate from This Plan. A plan 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 You or a Family Member has health care coverage under more than one Plan.

When This Plan is primary, Providence Health Plan determines payment for benefits first before those of any other plan without considering any other plan's benefits. When This Plan is secondary, PHP determines benefits after those of another plan and may reduce the benefits paid 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 You or a Family 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 You or a Family Member is not an Allowable Expense.

In addition, any expense for which a provider by law or in accordance with a contractual agreement is prohibited from charging 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 or a Family Member 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 or a Family Member is 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 or a Family Member is 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 from 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 or a Family Member has 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 who have contracted with or are 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.

8.3.2 Priority Between Plans

When a You or a Family 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 coverage that is superimposed over base plan Hospital and surgical benefits, and insurance-type coverage that is 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 Family Member other than as a Dependent, for example as a PEBB Member, is the Primary Plan, and the Plan that covers the Family Member as a Dependent is the Secondary Plan. However, if the Family Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Family Member as a Dependent; and primary to the Plan covering the Family 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 Family 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 Family 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. **PEBB Member or Retired or Laid-off Employee**. The Plan that covers a PEBB 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 PEBB Member as a retired or laid-off employee is the Secondary Plan. The same would hold true if a PEBB 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 PEBB Member or Family 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 providing coverage as an employee, subscriber or retiree or 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 PEBB Member as an employee, subscriber or retiree longer is the Primary Plan and the Plan that provided coverage for 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 would have been paid had it been the Primary Plan.

8.3.3 Effect on the Benefits of This Plan

When This Plan is secondary, benefits may be reduced 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 You or a Family 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.

8.3.4 Right to Receive and Release Necessary 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. Providence Health Plan may get the facts needed 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 You or a Family Member claiming benefits. Providence Health Plan need not tell, or get the consent of, any person to do this. Each individual claiming benefits under This Plan must give Providence Health Plan any facts needed to apply this section and determine benefits payable.

8.3.5 Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, the Plan 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. The Plan 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.

8.3.6 COB Right of Recovery

If the amount of the payments made by Providence Health Plan is more than should have been paid under this COB section, PHP may recover the excess from one or more of the persons paid or for whom benefits were paid, or any other person or organization that may be responsible for the benefits or Services provided for You or a Family Member. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of Services.

8.4 NON–DUPLICATION OF COVERAGE

8.4.1 Coordination with Medicare

In all cases, coordination of benefits with Medicare will conform to federal statutes and regulations. Medicare means Title XVIII of the Social Security Act, as enacted or amended. Medicare eligibility and how Providence Health Plan determines benefit limits under this Plan are affected by disability and employment status. Please contact Customer Service if You have questions.

9. PROBLEM RESOLUTION

9.1 INFORMAL PROBLEM RESOLUTION

All people who work with Providence Health Plan share responsibility for assuring Participant 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 Providence Health Plan's help. Customer Service is available to provide information and assistance. You may call PHP or meet with them at the phone number and address listed on Your Membership ID Card. If You have special needs, such as a hearing impairment, PHP will make efforts to accommodate Your requirements. Please contact Providence Health Plan so they may help You with whatever special needs You may have.

9.2 MEMBER GRIEVANCE AND APPEAL

9.2.1 Your Grievance and Appeal Rights

If You disagree with Providence Health Plan's decision about Your medical bills or health care services You have the right to three levels of internal review (an initial grievance, a first level appeal and a second level appeal). You may request a review if you believe the Plan has not paid a bill correctly, will not approve care that You believe should be covered or is stopping care You believe You still need. You may also file a quality of care or general complaint with PHP. Please include as much information as possible including the date of the incident, name 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 Providence Health Plan will consider that information in the review process.
- You can, upon request and free of charge, have reasonable access to and copies of the documents and records held by the Plan that relate to Your Grievance or appeal.

Time Frames: To the extent possible, complaints filed by telephone will be resolved at the point of service by Customer Service. All levels of Grievances and appeals (except those involving Prior Authorizations, as discussed below) will be acknowledged within seven days of receipt by Providence Health Plan and resolved within 30 calendar days or sooner depending on the clinical urgency. For an initial Grievance, Providence Health Plan may request an additional 15 days to resolve the issue if it provides You with a notice of delay, including a reason for the delay, before the 30-day period has elapsed.

Urgent Medical Conditions: If You believe Your health would be seriously harmed by waiting for Providence Health Plan's decision on Your Prior Authorization request, Grievance, or appeal, You may request an expedited review by calling Customer Service 503-574-7500 or 1-800-878-4445 outside the Portland area. Providence Health Plan will let You know by phone and letter if Your case qualifies for an expedited review. If it does, PHP will notify You of its decision within 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, Providence Health Plan will notify You of its decision

(a) Within 15 days after PHP receives Your request for an initial grievance or first level appeal or,
(b) Within 30 days of receiving Your request for a second level appeal.

Grievances and Appeals Involving Concurrent Care Decisions: If Providence Health Plan has approved an ongoing course of treatment for You and determines through its medical management procedures to reduce or terminate that course of treatment, it will provide advance notice to You of that decision. You may request reconsiderations of the decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. Providence Health Plan will then notify You of the reconsideration decision within 24 hours of receiving Your request.

9.2.2 Initial Grievance

You must file Your initial Grievance within 180 days of the date on Providence Health Plan's notice of initial decision, or that initial decision will become final. Please advise PHP 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 Providence Health Plan's decision on Your initial Grievance, You have the right to file a first level of appeal. Your appeal and any additional information You may want reviewed must be forwarded within 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 who were not involved in the initial Grievance.

9.2.4 Second Level of Appeal

If You are not satisfied with the first level of appeal decision, You may request that Providence Health Plan's Grievance Committee review Your appeal. The Grievance Committee is made up of Providence Health Plan staff and a community representative. You must request the Grievance Committee review within 60 days of 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 PHP's 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 or because they are Experimental/Investigational, **You may request an external review by an Independent Review Organization (IRO)**. Your request must be made within six months (180 days) of the receipt of the Grievance Committee's final internal review decision, or that internal decision will become final. If You agree, Providence Health Plan may waive the requirement that You exhaust the internal review process before beginning the external review process.

The IRO will notify You and Providence Health Plan of its decision. The IRO is not connected in any way to Providence Health Plan. PHP will abide by the IRO's decision and carry out its instruction. You are not responsible for the cost of an independent review. **Appeals involving benefit exclusions or non-covered Services are not eligible for independent review**.

9.2.6 How to Submit Grievances or Appeals

You may contact Customer Service at 503-574-7500 or 1-800-878-4445. If You are hearing impaired and use a Teletype (TTY) Device, please call PHP's 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 4447
Portland, Oregon 97208-4447

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, Suite 10
Beaverton, Oregon 97005

10. TERMINATION OF MEMBER COVERAGE

10.1 TERMINATION EVENTS

Termination of Participant coverage under the Plan will occur on the last day of the month in which a Participant becomes ineligible for coverage as specified in the eligibility provisions established by PEBB. The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the PEBB eligibility rules for detailed information on eligibility and termination of coverage.

10.2 NON-LIABILITY AFTER TERMINATION

Upon termination of this Plan, PEBB shall have no further liability for Services received beyond the effective date of the termination.

10.3 NOTICE OF CREDITABLE COVERAGE

The Plan will provide written certification of the Participant's period of Creditable Coverage when:

- A Participant ceases to be covered under the Plan;
- A Participant on COBRA coverage ceases that coverage; and
- A Participant requests a Notice of Creditable Coverage within 24 months of the termination of coverage.

11. CONTINUATION OF MEDICAL BENEFITS (COBRA)

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), a federal law that applies to employers with 20 or more employees, including PEBB, continuation of Plan coverage may be available in certain instances, as described in this section. The term "qualified beneficiary" is used in this section to refer to a Participant who is qualified for enrollment in COBRA continuation coverage.

11.1 COBRA QUALIFYING EVENTS

11.1.1 PEBB Member's Continuation Coverage

A PEBB Member who is covered by the Plan may elect continuation coverage under COBRA if coverage is lost because of termination of employment (other than for gross misconduct) or a reduction in work hours.

11.1.2 Spouse's or Domestic Partner's Continuation Coverage

A spouse or domestic partner who is covered by the Plan has the right to elect continuation coverage under COBRA if coverage is lost for any of the following qualifying events:

- The death of the PEBB Member;
- The termination of the PEBB Member's employment (for reasons other than gross misconduct) or reduction in hours;
- The divorce or legal separation of the PEBB Member and the spouse;
- Termination of the domestic partnership; or
- The PEBB Member becomes covered under Medicare.

11.1.3 Dependent's Continuation Coverage

A dependent child who is covered under the Plan has the right to continuation under COBRA if coverage is lost for any of the following qualifying events:

- The death of the PEBB Member;
- The termination of the PEBB Member's employment (other than for gross misconduct) or reduction in a PEBB Member's hours;
- The PEBB Member's divorce or legal separation;
- Termination of the domestic partnership;
- The PEBB Member becomes covered under Medicare; or
- The child ceases to qualify as an Eligible Family Member under the Plan.

A newborn child or a child placed for adoption who is properly enrolled under the terms of the Plan during the COBRA continuation period will be a qualified beneficiary.

11.2 NOTICE REQUIREMENTS

A Family Member's coverage ends on the last day of the month in which a divorce, legal separation or termination of domestic partnership occurs, or a child loses dependent status under the Plan. Under COBRA, You or Your Family Member has the responsibility to notify PEBB if one of these events occurs. Written notice must be given no later than 60 days after the loss of coverage has occurred, or the qualifying event, whichever is later. Oral notice is not binding until confirmed in writing. If notice is not timely given, continuation coverage will not be available.

When PEBB receives notification of one of the above "qualifying" events, You will be notified that You or Your Family Member, as applicable, has 60 days from the date coverage is lost or the date you receive the notice, whichever is later, to elect continuation coverage. If this election is not made within this 60-day period, Your right to elect continuation coverage under the Plan will be lost.

11.3 COBRA ADMINSTRATION SERVICES

PEBB has delegated the COBRA administration services to Benefit Help Solutions (BHS). You may contact BHS regarding COBRA administration matters at 503-765-3581 or 800-556-3137.

11.3 TYPE OF CONTINUATION COVERAGE

A qualified beneficiary will be provided the same coverage that was in effect immediately prior to the qualifying event.

11.4 COBRA ELECTION RIGHTS

A PEBB Member or his or her spouse or domestic partner may elect continuation coverage for all covered Family Members. In addition, each Family Member has an independent right to elect COBRA. Thus, a Family Member may elect continuation coverage even if the PEBB Member does not.

11.5 COBRA PREMIUMS

If You are eligible for COBRA continuation coverage, You do not have to show that You are insurable (that You do not have any serious health conditions). However, You must pay the full premium for Your continuation coverage, including the portion of the premium that PEBB was previously paying. After You elect COBRA, You will have 45 days from the date of election to pay the first premium. You must pay premium back to the point You would otherwise have lost coverage under the Plan. After that, You must pay the premium for each month as of the first of the month, and in all events within 30 days. If You fail to pay Your monthly premium, You will be notified that Your coverage is being terminated.

11.6 LENGTH OF CONTINUATION COVERAGE

11.6.1 18-Month Continuation Period

When coverage ends because of a PEBB Member's termination of employment (other than for gross misconduct) or a reduction in hours, the continuation period for the PEBB Member and all covered Family Members will be 18 months from the date of the qualifying event, or the date coverage is lost, whichever is later.

11.6.2 29-Month Continuation Period

If a Participant is disabled, continuation coverage for that qualified beneficiary and his or her covered Family Members may continue for up to 29 months from the date of the original qualifying event or loss of coverage, whichever is later. The 29-month period applies only if the following conditions are met:

- The Social Security Administration (SSA) determines that the qualified beneficiary is disabled at any time prior to the qualifying event or during the first 60 days of COBRA continuation coverage; and
- The qualified beneficiary provides PEBB with a copy of the SSA determination within the initial 18-month continuation period and not later than 60 days after the SSA determination was issued.

The premium for COBRA continuation coverage may increase after the 18th month to 150% of the otherwise applicable amount.

If the SSA makes a final determination of non-disability, the qualified beneficiary must notify the COBRA Administrator within 30 days. Written notification of non-disability should be provided to:

BenefitHelp Solutions
PO Box 67230
Portland, OR 97268-1230
Fax: 888-393-2943

11.6.3 36-Month Continuation Period

If a spouse, domestic partner or dependent child loses coverage because of any of the following reasons, COBRA provides for up to 36 months of continuation of coverage:

- The PEBB Member's death;
- The PEBB Member's eligibility for Medicare;
- Divorce or legal separation
- Termination of the domestic partnership; or
- A child becomes ineligible for dependent coverage.

11.6.4 Extension of Continuation Period

If second qualifying event occurs during the initial 18- or 29-month continuation period (for example, death of the employee, divorce, or child loses status as an Eligible Family Member under the Plan), coverage for a qualified beneficiary may be extended up to 36 months. However, in no case will the continuation coverage exceed 36 months from the date of the original qualifying event.

If a spouse or dependent child has continuation coverage because of the employee's termination or reduction in hours, and if the qualifying event occurred within 18 months after the employee became entitled to Medicare, the coverage period is extended to 36 months from the employee's Medicare entitlement date.

11.6.5 Extension of Coverage for a Spouse

If a surviving, divorced or legally separated spouse of a PEBB Member is at least 55 years old at the time of death or the dissolution or legal separation of the marriage, the spouse may be eligible to continue coverage under this Plan. This State of Oregon provision for 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 this Plan is terminated;
3. The date on which the surviving, divorced or legally separated spouse becomes covered under any other group health plan, including spousal coverage because of remarriage; or
4. The date on which the surviving, divorced or legally separated spouse becomes eligible for Medicare coverage.

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

11.7 THE TRADE ACT OF 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (TAA). TAA allows workers displaced by the impact of foreign trade, and individuals age 55 or older who are receiving pension benefits paid by the PBGC, to elect COBRA coverage during the 60-day period that begins on the first day of the month in which the individual first becomes eligible for TAA benefits. Eligible individuals can either take a tax credit or get advance payment of 65 percent of premiums paid for qualified health insurance, including continuation coverage. If You have questions about these tax provisions, You may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY caller may call toll-free at 1-266-686-4282. More information about the Trade Act is also available at **www.doleta.gov/tradeact/2002act_index.asp**.

11.8 WHEN COBRA CONTINUATION COVERAGE ENDS

Continuation coverage will end automatically for a qualified beneficiary when any of the following events occurs:

- PEBB no longer provides health coverage to any PEBB Members;
- The premium for the continuation coverage is not paid on time;
- The qualified beneficiary later becomes covered under another health plan that has no exclusions or limitations with respect to any pre-existing conditions. If the other plan has applicable exclusions or limitations, the COBRA continuation coverage will terminate after the exclusion or limitation no longer applies;
- The qualified beneficiary later becomes entitled to Medicare;
- The earliest date that the qualified beneficiary no longer qualifies for such coverage in accordance with COBRA regulations; or
- The applicable maximum period of continuation coverage occurs.

11.8 CONTINUATION OF COVERAGE AFTER COBRA COVERAGE ENDS

Under federal laws and state laws, individuals who exhaust their COBRA coverage are eligible to obtain ongoing coverage, under a separate policy, known as “portability” coverage. Additional information is available:

- For Oregon residents, by contacting the Oregon Insurance Division at 503-947-7980 or at this Web site: **www.cbs.state.or.us/external/ins/docs/consumer/coverage.htm#portability.**
- For Washington residents, by contacting the Washington Office of the Insurance Commissioner at 800-562-6900.

12. PORTABILITY PLANS

If Your medical coverage under this Plan terminates, Portability Plan coverage through the Oregon Medical Insurance Pool (OMIP) may be available.

OMIP does not form part of the Plan, nor is it sponsored or endorsed in any way by PEBB or Providence Health Plan. Rather, OMIP is authorized under Oregon law to provide Portability Plans to certain Oregon residents who lose coverage under a group Health Benefit Plan.

12.1 ELIGIBILITY

To be eligible for Portability coverage with OMIP You must meet the following requirements:

1. You must have been covered under one or more Oregon group Health Benefit Plans for at least 180 days;
2. You must apply for Portability coverage not later than the 63rd day after termination of Your group coverage;
3. You must be an Oregon resident at the time of application; and
4. If You are eligible for COBRA continuation coverage, You must exhaust that coverage.

You are NOT eligible for Portability coverage with OMIP if:

1. You are eligible for Medicare coverage;
2. You remain eligible for active group coverage or COBRA continuation 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.

12.2 EFFECTIVE DATE

Upon proper application and the payment of the applicable premiums, Portability coverage with OMIP will generally become effective on the day following the Participant's termination of COBRA continuation coverage under this Plan.

Please Note: In accordance with state mandated benefit provisions for Portability coverage, there is a 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.

For further information regarding Portability coverage with OMIP, and to receive an application for coverage, you may call the OMIP administrator, Regence BlueCross and BlueShield of Oregon, at 1-800-848-7280.

13. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

A child of a PEBB Member will be enrolled in the Plan as required by a qualified medical child support order. The procedures and rules regarding this enrollment are described in this section.

13.1 DEFINITIONS

For purposes of this section, the following definitions apply:

A “Participant” means any current or former PEBB Member who is covered, or who is eligible for coverage, under the Plan to which an Order is directed.

“Alternate Recipient” means any child of a Participant who is recognized under an Order as having a right to enrollment under the Plan with respect to such Participant.

An “Order” means any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction (or through an administrative process established under a state law which has the effect of a court order) which:

- Provides for child support with respect to a child of a Participant under the Plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under the Plan; or
- Enforces a state law relating to medical child support with respect to the Plan.

A “Qualified Medical Child Support Order” (QMCSO) means an Order:

- Which creates or recognizes the existence of an Alternate Recipient’s right to receive, or assigns to an Alternate Recipient the right to receive, benefits for which a Participant or beneficiary is eligible under the Plan; and
- With respect to which PEBB has determined satisfies the QMSCO standards set forth below.

“Procedures” means the Qualified Medical Child Support Order procedures as prescribed in this section.
“Designated Representative” means a representative designated by an Alternate Recipient to receive copies of notices that are sent to the Alternate Recipient with respect to an Order.

13.2 NOTICE UPON RECEIPT OF ORDER

Upon the receipt of any Order, PEBB will promptly notify the Participant and each Alternate Recipient identified in such Order of the receipt of such Order, and will further furnish them each with a copy of these Procedures. If the Order or any accompanying correspondence identifies a Designated Representative, then copies of the acknowledgment of receipt notice and these Procedures will also then be provided to such Designated Representative.

13.3 NOTICE OF DETERMINATION

Within a reasonable period after its receipt of the Order, PEBB will determine whether the Order satisfies the QMCSO standards prescribed below so as to constitute a QMCSO, and shall thereupon notify the Participant, each Alternate Recipient, and any Designated Representative of such determination.

An Order will not be deemed to be a QMCSO unless the Order:

- Clearly specifies:
  - The name and last known mailing address (if any) of the Participant and of each Alternate Recipient covered by the Order (or the name and mailing address of a State or agency official acting on behalf of the Alternate Recipient);
  - Either a reasonable description of the type of coverage to be provided under the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and
  - The period to which the Order applies.
- Does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent that the Order pertains to the enforcement of a state law relating to a medical child support.

If an Order contains inconsistencies or ambiguities that might pose a risk of future controversy or liability to the Plan, the Order will not be considered to be a QMCSO.

13.4 ENROLLMENT OF ALTERNATE RECIPIENT

An Alternate Recipient with respect to an Order determined to be a QMCSO who properly submits the applicable enrollment forms to PEBB will become covered under the Plan to which such Order applies as soon as practicable after the applicable enrollment forms are received. An Alternate Recipient will be eligible to become covered under the Plan as of a particular date without regard to any open enrollment period restrictions otherwise applicable under the Plan.

13.5 COST OF COVERAGE

An Alternate Recipient will be treated as having been voluntary enrolled in the Plan by the Participant as a dependent of such Participant, including in regard to the payment by the Participant for dependent coverage under the Plan. The amount of any required contributions to be made by the Participant for coverage under the Plan will be determined on the basis of the Alternate Recipient being treated as the Participant's covered dependent. Any additional required contribution attributable to the coverage of the Alternate Recipient will not be separately charged. Rather, the full amount of the required contribution shall be paid by the Participant in accordance with the payroll deduction or other procedures of the Plan as pertaining to the Participant.

13.6 REIMBURSEMENT OF PLAN EXPENSES

Unless the terms of the Order provide otherwise, any payments to be from the Plan as reimbursement for group health expenses paid either by the Alternate Recipient, or by the custodial parent or legal guardian of the Alternate Recipient, will not be paid to the Participant. Rather, such reimbursement will be paid either to the Alternate Recipient or to the Custodial Parent or legal guardian of such Alternate Recipient. However, if the name and address of a state or agency official has been substituted in the Order for that of the Alternate Recipient, then the reimbursement will be paid to such named official.

13.7 STATUS OF ALTERNATE RECIPIENT

An Alternate Recipient under a QMCSO generally will be considered a beneficiary of the Participant under the Plan to which the Order pertains.

13.8 TREATMENT OF NATIONAL MEDICAL SUPPORT NOTICE

If PEBB receives an appropriately completed National Medical Support Notice (NMSN) issued pursuant to the Child Support Performance and Incentive Act of 1998 in regard to a Participant who is a non-Custodial Parent of a child, and if the NMSN is determined by PEBB to satisfy the QMCSO standards prescribed above, then the NMSN shall be deemed to be a QMCSO with respect to such child.

PEBB, upon determining that the NMSN is a QMCSO, shall within 40 business days after the date of the NMSN notify the state agency issuing the NMSN of the following:

- Whether coverage of the child at issue is available under the terms of the Plan, and if so, whether such child is covered under the Plan; and
- Either the effective date of the coverage or, if necessary, any steps to be taken by the Custodial Parent (or by the state or agency official acting on behalf of the child) to effectuate the coverage under the Plan.

PEBB shall within such time period also provide to the Custodial Parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

Nothing in this section shall be construed as requiring the Plan, upon receipt of a NMSN, to provide benefits under the Plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the Plan as in effect immediately before receipt of such NMSN.

14. GENERAL PROVISIONS

14.1 DUPLICATING PROVISIONS

If any charge is described as covered under two or more benefit provisions, the Plan will pay only under the provision allowing the greater benefit. This may require a recalculation based upon both the amounts already paid and the amounts due to be paid. The Plan has NO liability for benefits other than those this Plan provides.

14.2 FAILURE TO PROVIDE INFORMATION

You warrant that all information contained in applications, questionnaires, forms, or statements submitted to PEBB and to Providence Health Plan and signed by You to be true, correct, and complete. If You willfully fail to provide information required to be provided under this Plan or knowingly provide incorrect or incomplete information, then Your rights and those of Your Family Members may be terminated as described in the Disenrollment section.

14.3 MEMBER RESPONSIBILITY

It is Your responsibility to read and to understand the terms of this Plan. Neither PEBB nor Providence Health Plan will have any liability whatsoever for Your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If You have any questions or are unclear about any provision concerning this Plan, please contact Providence Health Plan for assistance in understanding and complying with the terms of the Plan.

14.4 MEMBERSHIP ID CARD

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

14.5 NON-TRANSFERABILITY OF BENEFITS

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

14.6 NONWAIVER

No delay or failure when exercising or enforcing any right under this Plan shall constitute a waiver or relinquishment of that right, and no waiver or any default under this Plan shall constitute or operate as a waiver of any subsequent default. No waiver of any provision of this Plan shall be deemed to have been made unless and until such waiver has been reduced to writing and signed by the party waiving the provision.

14.7 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. Neither PEBB nor Providence Health Plan is 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.

14.8 NOTICE

Any notice required of PEBB or Providence Health Plan under this Plan shall be deemed to be sufficient if mailed to the Participant 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 at P.O. Box 4447 Portland, OR 97208.

14.9 NOTICE REQUIRED FOR REIMBURSEMENT AND PAYMENT OF CLAIM

Plan payments for most Services are made directly to the providers of Services. Except as otherwise specifically provided in this Plan, if You are billed directly and pay for benefits which are covered by this Plan, reimbursement from the Plan will be made only upon Your written notice to Providence Health Plan of the payment. Payment will be made to the Participant, subject to written notice of claim, or, if deceased, to the Participant's estate, unless payment to other parties is authorized in writing by you. See section 8.3.8 regarding timely submission of claims.

14.10 PHYSICAL EXAMINATION AND AUTOPSY

When reasonably required for purposes of claim determination, PEBB shall have the right to make arrangements for the following examinations, at Plan expense, and to suspend the related claim determination until Providence Health Plan has received and evaluated the results of the examination:

- A physical examination of a Participant; or
- An autopsy of a deceased Participant, if not forbidden by law.

14.11 PROFESSIONAL REVIEW AND RIGHT TO EXAMINE RECORDS

All Participants, by acceptance of the benefits of this 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 their designee.

All Participants, for purposes other than utilization review, quality assurance and peer review, may be required to authorize any provider to give and discuss with Providence Health Plan any information relating to any condition for which benefits are claimed under this Plan. Providence Health Plan may transfer this information between providers or other organizations who are treating You or performing a service on behalf of PHP. If You do not consent to the release of records or to discussions with providers, Providence Health Plan 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 examine nor the actual examination of the records or discussion with providers will constitute a guarantee of payment.

14.12 SEVERABILITY

Invalidation of any term or provision herein by judgment or court order shall not affect any other provisions, which shall remain in full force and effect.

14.13 SUGGESTIONS

You are encouraged to make suggestions to PHP. Suggestions may be oral or written and should be directed to Customer Service at the Providence Health Plan administrative office.

14.14 WORKERS' COMPENSATION INSURANCE

This Plan is not in lieu of, and does not affect, any requirement for coverage by Workers' Compensation or similar laws.

14.15 NO GUARANTEE OF EMPLOYMENT

Neither the maintenance of the Plan nor any part thereof shall be construed as giving any PEBB Member covered hereunder or other PEBB Members any right to remain in the employ of the State of Oregon. No employee or official of PEBB in any way guarantees to any Participant or beneficiary the payment of any benefit or amount that may become due in accordance with the terms of the Plan.

14.16 REQUIRED INFORMATION TO BE FURNISHED

Each Participant must furnish Providence Health Plan such information as considered necessary or desirable for purposes of administering the Plan, and the provisions of the Plan respecting any payments hereunder are conditional upon the prompt submission by the Participants of such true, full and complete information as Providence Health Plan may request.

14.17 PAYMENT OF BENEFITS TO PERSONS UNDER LEGAL DISABILITY

Whenever any person entitled to payments under the Plan is determined to be a minor or under other legal disability or otherwise incapacitated in any way so as to be unable to manage such person's financial affairs, or otherwise incapable of giving a valid receipt and discharge for any payment, the following provision shall apply. Providence Health Plan, in its discretion, may direct that all or any portion of such payments be made (i) to such person, (ii) to such person's legal guardian or conservator, or (iii) to such person's spouse or to any other person, in any manner which PHP considers advisable, to be expended for the person's benefit. Providence Health Plan's decision will, in each case, be final and binding upon all persons. Any payment made pursuant to the power herein conferred shall operate as a complete discharge of the obligations under the Plan in respect thereof by PEBB and Providence Health Plan.

14.18 STATE MEDICAID BENEFITS RIGHTS

Notwithstanding any provision of the Plan to the contrary:

- Payment for benefits with respect to a Participant under the Plan shall be made in accordance with any assignment of rights made by or on behalf of such Participant, or a Family Member, as required by a State Medicaid Plan;
- The fact that an individual is eligible for or is provided medical assistance under a State Medicaid Plan shall not be taken into account in regard to the individual's enrollment as a Participant or beneficiary in the Plan, or in determining or making any payments for benefits of the individual as a Participant or Family Member in the Plan; and
- Payment for benefits under the Plan shall be made to a state in accordance with any state law that provides that the state has acquired the rights with respect to a Participant for items or services constituting medical assistance under a State Medicaid Plan.

For purposes of the above, a "State Medicaid Plan" means a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act.

14.19 VETERAN'S RIGHTS

The Plan will provide benefits to Participants entering into or returning from service in the United States armed forces as may be required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). In general, USERRA provides that:

A Participant who takes unpaid military leave, or who separates from employment to perform services in the armed forces or another uniformed service, can elect continued coverage under the Plan (including coverage for the Eligible Family Dependents) on a self-pay basis. The applicable Contribution for such coverage, and the Contribution payment procedures, shall be as generally prescribed for COBRA continuation coverage in section 11. Effective for elections made on or after December 10, 2004, the period for such continuation coverage shall extend until the earlier of:

(a) The end of the 24-month period beginning on the date on which the Participant's absence for the purpose of performing military service begins; or

(b) The date the Participant fails to timely return to employment or reapply for a position covered by PEBB upon the completion of such military service.

14.20 CONTROLLING STATE LAW

The laws of the State of Oregon shall apply and shall be the controlling state law in all matters relating to the Plan.

14.21 LIMITATIONS ON PROVISIONS

The provisions of the Plan and any benefits provided by the Plan shall be limited as described herein. Any benefit payable under any other employee benefits plan maintained by PEBB shall be paid solely in accordance with the terms and provisions of such plan, and nothing in this Plan shall operate or be construed in any way to modify, amend, or affect the terms and provisions of such other plan.

14.22 GENDER AND NUMBER

Masculine gender shall include the feminine and neuter, the singular shall include the plural, and the plural shall include the singular, unless the context clearly indicates otherwise.

14.23 HEADINGS

All article and section headings in the Plan are intended merely for convenience and shall in no way be deemed to modify or supplement the actual terms and provisions set forth thereunder.

14.24 CONFLICTS OF PROVISIONS

In the event that one or more provisions of this document conflict with one or more provisions of any other plan document, the provisions of this document, as from time to time amended, shall control.

14.25 LEGAL ACTION

No civil action may be brought under state or federal law to recover Plan benefits until receipt of a final decision under the Member Grievance and Appeal process specified in section 9.2 of this Member Handbook.

14.26 PROTECTED HEALTH INFORMATION

Disclosure: In accordance with the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA), Providence Health Plan may disclose de-identified summary health information to PEBB for purposes of modifying, amending or terminating this Plan. In addition, Providence Health Plan may disclose protected health information (PHI) to PEBB in accordance with the following provisions of this Plan as established by PEBB:

(a) PEBB may use and disclose the PHI it receives only for the following purposes:
   1. Administration of the Plan; and
   2. Any use or disclosure as required by law.

(b) PEBB shall ensure that any agent or subcontractor to whom it discloses such PHI shall agree to the same restrictions and conditions that apply to PEBB with respect to such information.

(c) PEBB shall not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of PEBB.

(d) PEBB shall report to PHP any use or disclosure of PHI that is inconsistent with the provisions of this section of which the Employer becomes aware.

(e) PEBB shall make PHI available to Participants in accordance with the privacy regulations of HIPAA.

(f) PEBB shall allow Participants to amend their PHI in accordance with the privacy regulations of HIPAA.

(g) PEBB shall provide Participants with an accounting of its disclosure of their PHI in accordance with the privacy regulations of HIPAA.

(h) PEBB shall make its internal practices, books and records relating to the use and disclosure of PHI received from PHP available to the Secretary of the Department of Health and Human Services in accordance with the privacy regulations of HIPAA.

(i) PEBB shall, if feasible, return or destroy all PHI received from PHP and retain no copies of such information when no longer needed for the purpose for which such information was received except that, if such return or destruction is not feasible, PEBB shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(j) PEBB shall provide for adequate separation between PEBB and PHP with regard to the use and disclosure of PHI. For that purpose, access to PHI shall be limited to the following employees or classes of employees of PEBB or designated individuals:
   1. Benefit Manager;
   2. Director of Operations;
   3. PEBB's Designated Consultants; and
   4. Internal Auditors, including representatives of the Oregon Secretary of State or Department of Justice, when performing health plan audits.

Further, PEBB shall restrict the access to and use of PHI by the employees designated above to the administrative functions that those employees perform for PEBB with regard to this Plan. In addition, PEBB shall establish an effective mechanism for resolving any issues of noncompliance by the employees designated above with regard to their use of PHI.

Security: In accordance with the security standards of HIPAA, PEBB shall:

(a) Implement administrative, physical, and technical safeguards that protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;

(b) Ensure that the separation of access to PHI that is specified in paragraph (j) above is supported by appropriate security measures;

(c) Ensure that any agent or subcontractor to whom PEBB provides PHI agrees to implement appropriate security measures to protect such information; and

(d) Report to the Plan any security incident regarding PHI of which PEBB becomes aware.

15. DEFINITIONS

The following are definitions of important terms used in this Plan and appear throughout as capitalized text.

Benefit Summary

Benefit Summary means the provisions specified in section 2 of this Member Handbook.

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 for a Covered Service that is a percentage of the allowable fee under this Plan for the Covered Service, as shown in the Benefit Summary.

Confinement

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

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

Contribution

Contribution means the dollar amount that a Participant may be required to pay as a condition to coverage under the Plan toward the monthly premium cost of the Plan established by PEBB.

Copayment

Copayment means the dollar amount that You are responsible for paying to a health care provider when You receive certain Covered Services, as shown in the Benefit Summary.

Cosmetic Services

Cosmetic Services means Services or surgery performed to reshape normal 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 Benefit Summary and in the Covered Services section of this Member Handbook;
2. Medically Necessary;
3. Not listed as an Exclusion or Limitation in the Benefit Summary or in the relevant sections of this Member Handbook; and
4. Provided to You while You are a Participant and eligible for the Service under this 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 Participant 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, Indian Health Service or tribal organization coverage, state high-risk pool coverage, or a domestic or foreign public health plan as defined in 42 U.S.C. § 300gg.

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 Participant or the Participant's spouse or domestic partner. See also Eligible Family Dependent.

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 Plan commences for a PEBB Member, which shall be: The first day of the month after which a PEBB Member is properly enrolled.

Eligible Family Dependent – See section 4.2

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.

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.

E-visit

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

Exclusion Period

Exclusion Period means a period of time during which specified treatments or Services are excluded from coverage under this Plan, unless such exclusion is modified or eliminated by the application of Creditable Coverage.

Experimental/Investigational

Experimental/Investigational means those Services that are determined by Providence Health Plan not to be Medically Necessary or accepted medical practice in the Service Area, including Services performed for research purposes. In determining whether Services are Experimental/Investigational, Providence Health Plan, as the Plan's claims administrator, will consider whether the Services are in general use in the medical community in the United States 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. Providence Health Plan determines 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. Providence Health Plan 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 the Plan, entitled to Services and covered under this Plan.

Grievance

Grievance means a written complaint that may be submitted by or on behalf of a Participant 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 Participant and the Plan.

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 ERISA.

Home Health Provider

A Home Health Provider is 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 that:

1. Maintains permanent full-time facilities for bed care of resident patients;
2. Has a physician or surgeon in regular attendance;
3. Provides continuous 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, convalescent home or home for the aged. Hospital does NOT include a place principally for the treatment of Chemical Dependency or Mental Health disorders.

In-Plan

The level of benefits specified in the Benefit Summary or covered Services provided by a provider participating in the PEBB Statewide Plan network.

Lifetime Maximum Benefit

Lifetime Maximum Benefit means the $2 million limit of total benefits payable by the Plan during the lifetime of a Participant while enrolled in a medical plan sponsored by PEBB.

For each calendar year that a Participant is enrolled on this Plan, the Plan will restore to the Participant's Lifetime Maximum Benefit, the following amount:

- If benefits paid by the Plan for a Participant's Covered Services in the calendar year total $25,000 or less, then on January 1 of the following year, the Plan will restore the full amount of the benefits paid to the Participant's Lifetime Maximum Benefit.
- If the benefits paid by the Plan for a Participant's Covered Services in the calendar year are in excess of $25,000, then the Plan will restore $25,000 to the Participant'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 the Providence Health Plan. 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 the Plan.

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 within promising efficacy, 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 year of the date of the request for diagnosis or treatment.

Member Handbook

Member Handbook means this document, which summarizes the provisions of this Plan.

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:

1. Diagnostic codes relating to Mental Retardation - 317 (Mild), 318.0 (Moderate), 318.1 (Severe), 318.2 (Profound) and 319 (Severity Unspecified);
2. Diagnostic codes relating to Learning Disorders - 315.00 (Reading), 315.1 (Mathematics), 315.2 (Written Expression) and 315.9 (Not Otherwise Specified);
3. Diagnostic codes relating to Paraphilias - 302.2 (Pedophilia), 302.4 (Exhibitionism), 302.81(Fetishism), 302.82 (Voyeurism), 302.83 (Sexual Masochism), 302.84 (Sexual Sadism), 302.89 (Frotteurism) and 302.9 (Not Otherwise Specified);
4. Diagnostic codes relating to Gender Identity Disorders in Adults - 302.6 (Not Otherwise Specified), 302.85 (Gender Identity) and 302.9 (Sexual Disorder Not Otherwise Specified). This exception does not extend to children and adolescents 18 years of age or younger; and
5. Diagnostic "V"codes - V15.81 (Noncompliance With Treatment), V61.1 (Partner Relational Problem) (Physical or Sexual Abuse of Adult), V61.20 (Parent-Child Relational Problem), V61.21 (Sexual or Physical Abuse or Neglect of Child), V61.8 (Sibling Relational Problem, V61.9 (Relational Problem Related to a [a mental Disorder or General Medical Condition]), V62.2 (Occupational Problem), V62.3 (Academic Problem), V62.4 (Acculturation Problem), V62.81 (Relational Problem Not Otherwise Specified), V62.82 (Bereavement), V62.89 (Phase of Life Problem) (Religious or Spiritual Problem) (Borderline Intellectual Functioning), V65.2 (Malingering), V71.01 (Adult Antisocial Behavior), V71.02 (Child or Adolescent Antisocial Behavior), V71.09 (No Diagnosis or Condition on Axis I or Axis II). 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, Hospital, Qualified Practitioner, Qualified Treatment Facility, or Skilled Nursing Facility that does not have a written agreement with Providence Health Plan to participate as a health care provider for this Plan.

Open Enrollment Period

Open Enrollment Period means the period determined by PEBB during which PEBB Members and their Eligible Family Dependents may enroll in this Plan for the upcoming Plan Year, subject to the terms and provisions as found in the Eligibility and Enrollment section of this Member Handbook.

Out-of-Plan

The level of benefit specified in the Benefit Summary for Covered Services provided by a Non-Participating Provider.

Out-Of-Pocket Maximum

Out-of-Pocket Maximum means the calendar year threshold at which this Plan will begin to pay for Covered Services at 100%, as follows:

1. Individual Out-of-Pocket Maximum means the amount of Coinsurance and Copayment within a calendar year, as shown in the Benefit Summary, that a Member must pay before this Plan will provide 100% benefits* for additional Covered Services within the calendar year.* Covered Services that are indicated in the Benefit Summary as not applicable to the Out-of-Pocket Maximum are NOT eligible for 100% benefits. The Copayment or Coinsurance for those Services that is shown in the Benefit Summary remains in effect throughout the calendar year.
2. Family Out-of-Pocket Maximum means the combined amount of Coinsurance and Copayment within a calendar year, as shown in the Benefit Summary, that all Family Members must pay before this Plan will provide 100% benefits* for additional Covered Services within the calendar year.* Covered Services that are indicated in the Benefit Summary as not applicable to the Out-of-Pocket Maximum are NOT eligible for 100% benefits. The Copayment or Coinsurance for those Services that is shown in the Benefit Summary remains in effect throughout the calendar year.

The family Out-of-Pocket Maximum will be satisfied if:

- Three Family Members each meet their individual Out-of-Pocket Maximum, or
- Four or more Family Members have combined Coinsurance or Copayment expenses that meet the family Out-of-Pocket Maximum amount.

Separate Accumulation: Your In-Plan and Out-of-Plan Out-of-Pocket Maximums accumulate separately and are not combined.

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

1. Services not covered by this Plan;
2. Services in excess of any maximum benefit limit;
3. Fees in excess of the Usual, Customary and Reasonable (UCR) charges;

Copayments or Coinsurance for a Covered Service if indicated on the Benefit Summary as not applicable* to the Out-of-Pocket Maximum.* Covered Services that are indicated in the Benefit Summary as not applicable to the Out-of-Pocket Maximum are NOT eligible for 100% benefits. The Copayment or Coinsurance for those Services that is shown in the Benefit Summary remains in effect throughout the calendar year;

4. Copayments or Coinsurance for prescription drugs;
5. Any penalties a Participant must pay for failure to obtain the required Prior Authorization for specified Services;
6. Copayments or Coinsurance for infertility Covered Service;
7. Copayments or Coinsurance for Services provided through Unified Life;
8. Copayments or Coinsurance for alternative care services; and
9. Copayments or Coinsurance for hearing exams or hearing aids.

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 and does NOT provide Services or accommodations for patients to stay overnight.

Participant

Participant means a PEBB Member or an Eligible Family Dependent who is properly enrolled in this Plan, and entitled to Services under this Plan.

Participating Provider

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

Personal Physician/Provider

Personal Physician/Provider means a Qualified Practitioner in the PEBB Statewide Plan Network specializing in family practice, general practice, internal medicine or pediatrics; or a nurse practitioner 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 in the PEBB Statewide Plan Network, please see the Online Participating Provider Directory or call Customer Service.)

PEBB

PEBB means the Oregon Public Employees' Benefit Board, the sponsor of this Plan.

PEBB Member

PEBB Member means an Oregon public employee or former employee who is eligible for enrollment in this Plan in accordance with the provisions specified in the PEBB Eligibility Handbook and the Oregon Administrative Rules, Chapter 101.

PEBB Statewide Plan Network

PEBB Statewide Plan Network means the network of Participating Providers in Oregon that Participants may access for Covered Services under this Plan.

Plan

Plan means the group health plan sponsored by PEBB, as summarized in this Member Handbook.

Plan Year

Plan Year means the 12-month period ending on December 31.

Portability Plan

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 Providence Health Plan by You or by a Qualified Practitioner regarding a proposed Service, for which prior approval is granted by PHP. Prior Authorization review will determine if the proposed Service is eligible as a Covered Service or if an individual is a participant at the time of the proposed Service. Prior Authorization is subject to the terms and provisions of this Member Handbook. Prior Authorization is not a guarantee of benefit payment (e.g., if the Participant's coverage terminates before the Prior Authorized procedure is performed). See section 3.4.

Providence Health Plan (PHP)

Providence Health Plan or PHP means the nonprofit corporation authorized as a health care service contractor in the states of Oregon that serves as the claims administrator with respect to this Plan.

Qualified Practitioner

Qualified Practitioner means a physician, women's health care provider, nurse practitioner, certified nurse 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 mean a health care related procedure, surgery, consultation, advice, diagnosis, referral, treatment, supply, medication, prescription drug, device or technology that is provided to a Participant by a Qualified Practitioner.

Service Area

Service Area means the state of Oregon.

Skilled Nursing Facility

Skilled Nursing Facility means a convalescent or chronic disease facility that is accredited by the Joint Commission on Accreditation of Hospitals or certified as a "Skilled Nursing Facility" by the Secretary of Health and Human Services pursuant to Title XVIII of the Social Security Act as amended.

Telemedical Visit

Telemedical Visit means a two-way video communication with a Qualified Practitioner in which the Qualified Practitioner is able to interact with the Participant. Telemedical Visits must be Medically Necessary and must be for an illness or injury that is otherwise covered under the Plan.

Urgent/Immediate Care

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

Usual, Customary and Reasonable (UCR)

When a Service is provided by a Participating Provider, UCR means the fees that Providence Health Plan has negotiated with Participating Providers for that Service. UCR charges will never be less than the Plan's negotiated fees.

When a Service is provided by a Non-Participating Provider, UCR charges will 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

A 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.

You and Your

You and Your means a PEBB Member or other Participant.