

Providence Individual and Family Plans

Limitations and Exclusions

Some benefit limitations and exclusions apply to all of our plans. Benefit plans typically have exclusions and limitations – what the plans do not cover. **The following is an overview of the most common exclusions and limitations that apply to our plans.** Upon enrollment, you will be given a policy with a complete description of your coverage. Refer to the Plan Contract for additional information about exclusions and limitations or call our Sales Department at 503-574-5000 or 1-800-988-0088.

Exclusion Period

- An exclusion period is the period of time specific treatments and services are not covered by the health plan.
- **Pre-existing condition:** A pre-existing condition is a medical condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the effective date of coverage. You must be on our plan for six months before treatment and services for a preexisting condition will be covered.
- **Elective procedures:** An elective procedure is one that can be postponed for treatment during the limitation period. You must be on our plan for 12 months before treatment and services will be covered.
- **Organ transplant:** You must be on our plan for 24 months before we pay benefits for organ transplants.
- **Newborns:** Exclusion periods are waived for a newborn or adopted child if the child is enrolled on the plan within 60 days of birth or adoption placement.

Creditable Coverage

If you were covered on another health plan within 63 days before your effective date of coverage, you may have “creditable coverage.” Your creditable coverage will be applied month for month toward the plan exclusion periods. You will need to provide us with a copy of your Certificate of Creditable Coverage (obtain from your prior health carrier).

Limited Covered Services

Certain covered services have a coverage maximum for a set period of time. Limitations are set by either a maximum dollar or day/visit amount. Once the plan maximum is met, you will be responsible for costs until a new limitation period begins. The services below are subject to limitations and maximum coverage amounts.

Covered service	Plan Maximum
Rehabilitative Care Inpatient Care Outpatient Care	30 days per calendar year 30 visits per calendar year
Skilled Nursing Facility Care	60 days per calendar year
Home Health Care	180 visits per calendar year
Durable Medical Equipment	\$2,500 per member per year
Removable shoe orthotics	\$200 per calendar year
Ambulance Services	\$2,000 per calendar year
Mental Health Treatment	\$2,000 per calendar year for all services, inpatient or outpatient
Alcohol Treatment	\$4,500 per 2 calendar years
Transplant services	\$250,000 lifetime maximum
Lifetime maximum coverage for all benefits	\$2,000,000

Exclusions

- Alternative care, including massage, acupuncture and naturopathic care
- Chemical dependency, except as noted for alcohol treatment
- Chiropractic services
- Cosmetic surgery, including prescription drugs
- Custodial care and private nursing services
- Dental care
- Experimental or investigational procedures, including prescription drugs
- Fertility/infertility treatment, services, supplies, prescription drugs
- Genetic testing
- Hearing aids/devices, screening and exams
- Home births and all related services
- Certain mental health services, including all residential/day treatment, treatment of developmental or learning disabilities; and self help programs, including family, marriage, sex and career counseling in the absence of illness.
- Physical exams primarily for camps, sports, insurance, licensing, employment, or other third party purposes
- Sexual dysfunction or sexual transformation services, supplies or prescription drugs
- Voluntary sterilization or termination of pregnancy
- Temporomandibular joint (TMJ) services and orthognathic surgery
- Treatment for tobacco addiction, including prescription drugs
- Obesity or weight control treatment, including surgery and prescription drugs
- Services for injury/illness sustained as a result of any work for wage or profit
- Services covered by motor vehicle insurance or other liability insurance
- Vision services or supplies (*Prime Plan only*)
- Services not provided by a Participating Provider or Participating Facility (*Prime Plan only*)

Prescription Drug Exclusions

- Drugs not listed in our plan formulary
- Drugs not directly related to treatment of a covered illness or injury
- Over-the-counter (OTC) drugs, medications, or vitamins and prescription drugs for which there are OTC therapeutic equivalents
- Drugs used in the treatment of fungal nail conditions
- Drugs used in the treatment of the common cold
- Intrauterine devices (IUDs), diaphragms
- Amphetamines and derivatives, except for narcolepsy or hyperactivity treatment
- Drugs used to treat shift-sleep disorder, drug induced fatigue or general fatigue
- Fluoride, for members over the age of 10 years old
- Drugs to stimulate hair growth
- Most injectable medications must be purchased through Providence Home Infusion and are only covered if they are: intended for self-administration; labeled by FDA for self-administration; and on our list of "Self Administered Injectable Drugs."
- Drugs that are placed on prescription-only status by federal or state mandate outside of required FDA-status assignment