Providence Health Plan

2025 Oregon Member Handbook

HSA Qualified Signature Network

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PROVIDENCE HEALTH PLAN QUICK REFERENCE GUIDE

Please see our Quick Reference Guide for customer service information.

Customer Service Quick Reference Guide:

General assistance with your Plan	503-574-7500 (local / Portland area) 800-878-4445 (toll-free) 711 (TTY) ProvidenceHealthPlan.com
Medical, Mental Health, and Substance Use Disorder Prior Authorization requests	800-638-0449 (toll-free) 503-574-6464 (fax)
Providence Nurse Advice Line	503-574-6520 (local / Portland area) 800-700-0481 (toll-free) 711 (TTY)
Provider Directory	ProvidenceHealthPlan.com/findaprovider

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1. INTRODUCTION

Thank you for choosing Providence Health Plan. We look forward to meeting your health care needs. The following is a brief outline of several key aspects of your HSA Qualified Signature Network Large Group Plan.

- Some capitalized terms have special meanings. Please see section 14, Definitions.
- In this handbook, your HSA Qualified Signature Network Large Group Plan is referred to as "Large Group Plan" or "Plan."
- In this handbook, Providence Health Plan is referred to as "we," "us" or "our." Members enrolled under this Plan are referred to as "you" or "your."
- Coverage under this Large Group Plan is provided, as listed in your Benefit Summary through:
    - Our Providence Signature In-Network Providers located in our Service Area, as applicable to your Plan; or
    - Our Extend PPO In-Network Providers located in our Service Area, as applicable to your Plan;
    - Our national In-Network Providers; and
    - Out-of-Network Providers.
- Members will generally have lower out-of-pocket expenses when obtaining Covered Services from In-Network Providers. Members may, however, obtain most Covered Services from Out-of-Network Providers, but that option will result in higher out-of-pocket expenses. Please see section 4 and your Benefit Summary for additional information.
- Some Services are covered only under your In-Network benefits:
    - Tobacco Use Cessation Services, as specified in section 4.1.8;
    - Telehealth Services, as specified in section 4.3.2;
    - E-mail Visit Services, as specified in section 4.3.3;
    - Temporomandibular Joint (TMJ) Services, as specified in section 4.12.7;
    - Human Organ/Tissue Transplant Services, as specified in section 4.13;
    - Prescription Drug Services, as specified in section 4.11;
    - Any Supplemental Benefit included with your Plan that is designated as In-Network only, as specified in section 13; and
    - Any item listed in your Benefit Summary as "Not Covered" under Out-of-Network.
- Your Deductible is the dollar amount you must pay each Calendar Year before we provide benefits for Covered Services. Coverage is provided in full without meeting the Deductible for Core Preventive drugs, subject to formulary tier, and most In-Network preventive care. See your Benefit Summary for Covered Services subject to the Deductible and additional information.
- Your plan requires assignment of a Primary Care Provider. If you do not select a Primary Care Provider within 90 days of coverage beginning, you will be assigned one in your area.
- A printable directory of In-Network Providers in our Service Area and our national In-Network Providers is available at ProvidenceHealthPlan.com/findaprovider. Members without Internet access or who would like a hard copy of our Provider Directory, may contact Customer Service for assistance.
- **Certain Covered Services require an approved Prior Authorization, as specified in section 3.5.**
- If there are no In-Network providers in your area, or if you require unique Medically Necessary skills or Services that are not available from any In-Network providers in your

area, you may request a Prior Authorization to be seen by an Out-of-Network provider or facility at the cost of your In-Network benefit. Allowable charges are based on Usual, Customary, and Reasonable (UCR) rates. These Services may be subject to review for Medical Necessity.

- Coverage limitations and exclusions apply to certain Services, as stated in sections 3, 4, 5 and the Benefit Summary.
- Coverage under this Large Group Plan is available 24 hours a day, seven days a week and during periods of domestic or foreign travel.
- All Covered Services are subject to the provisions, limitations and exclusions that are specified in this Plan. You should read the provisions, limitations and exclusions before seeking Covered Services because not all health care services are covered by this Plan.
- The Group Contract for this Plan consists of this Member Handbook plus the Employer/Group Agreement, Rate Summary, Benefit Summaries, any Endorsements and amendments that accompany these documents, and those policies maintained by Providence Health Plan which clarify any of these documents. In the event of any conflict between these documents, they are to be interpreted in the following order of priority: (1) Endorsements and amendments, (2) Employer/Group Agreement, (3) Member Handbook, (4) Benefit Summary, (5) Rate Summary, and (6) applicable Providence Health Plan policies.

2. WELCOME TO PROVIDENCE HEALTH PLAN

Providence Health Plan is an Oregon licensed Health Care Services Contractor whose parent company is Providence Health & Services. This Plan provides access to a network of Hospitals, clinics, urgent care centers, physicians and other health care providers. Our goal is to help improve the health status of individuals in the communities in which we serve.

2.1 YOUR HSA QUALIFIED SIGNATURE NETWORK PLAN

The coverage under this Plan is Health Savings Account-qualified, which means that this Plan qualifies as a High Deductible Health Plan (HDHP) for use in connection with a Health Savings Account (HSA). Your potential eligibility for this Plan as being Health Savings Account qualified means that it may be paired with an employer sponsored HSA. HSA status is not automatic with enrollment in this HDHP.

Health Savings Account (HSA)

An HSA is a federally legislated way for people to save pre-tax dollars for future medical expenses or for retirement. An HSA operates much like an individual retirement account (IRA): you, and/or your Employer, can choose to contribute to the account. However, *you* own your HSA, even if your Employer has contributed to it. Money in your account can roll over from year to year and you can take the account with you if you change jobs. Your HSA is a significant tax-free investment.

HSAs are managed by HSA trustees, usually a bank or other financial institution. Usually your Employer chooses the bank that will administer your Health Savings Account. Your Employer will share this bank information with you. **For Health Savings Account information, including investment options and the availability of a debit card, you should consult the bank administering your HSA.** For other details on banking and IRS regulations, please consult your tax or investment advisor, or visit the IRS website at treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx.

Note: Should the criteria for federal qualifications on HSA-qualified High Deductible Health Plans be revised or clarified in a way that would result in non-qualification of this Plan, we may initiate an amendment in order to maintain that qualification. This Plan is also disqualified as an HSA-Qualified plan if it is provided alongside a Health Reimbursement Account (HRA).

Your Large Group Plan

Your HSA Qualified Signature Network Plan allows you to receive Covered Services from In-Network Providers through what is called your In-Network benefit. You also have the option to receive most Covered Services from Out-of-Network Providers through what is called your Out-of-Network benefit. Generally, your out-of-pocket costs will be less when you receive Covered Services from In-Network Providers. Also, In-Network Providers will work with us to Prior Authorize treatment. If you receive Covered Services from Out-of-Network Providers, it is your responsibility to make sure the Services listed in section 3.5 are Prior Authorized by us before treatment is received.

It is your responsibility to verify whether or not a physician/provider, Hospital or other facility is an In-Network Provider and whether or not the health care is a Covered Service even if you have been directed or referred for care by an In-Network Provider.

If you are unsure about a physician/provider's, Hospital's or other facility's participation with Providence Health Plan, visit our Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider, before you make an appointment. You can also call Customer Service to get information about a provider's participation with Providence Health Plan and your benefits.

Whenever you visit a Provider:

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

2.2 MEMBER HANDBOOK

The member handbook contains important information about the health plan coverage we offer to employees of Oregon Employers. It is important to read this Member Handbook carefully as it explains your Providence Health Plan benefits and Member responsibilities. If you do not understand a term that is used, you may find it in Definitions, section 14. If you need additional help understanding anything in this Member Handbook, please call Customer Service at 503-574-7500 or 800-878-4445. *See section 2.3 for additional information on how to reach Customer Service.*

This Member Handbook is not complete without your:

- **Large Group Benefit Summary** and any other Supplemental Benefit Summary documents. These documents are available when you register for a myProvidence account as explained in section 2.4. Benefit Summaries detail your Copayments and Coinsurance for Covered Services and also provide important information for any Supplemental Benefits you may have, like Massage Therapy, Vision and Bariatric Surgery.
- **Provider Directory** which lists In-Network Providers, available online at ProvidenceHealthPlan.com/findaprovider. If you do not have Internet access, please call Customer Service or check with your Employer's human resource department to obtain a hard copy of the directory.

If you need more detailed information for a specific problem or situation, contact your Employer or Customer Service.

2.3 CUSTOMER SERVICE

We want you to understand how to use your Providence Health Plan benefits and to be satisfied with your health plan coverage. Customer Service is available to assist you in understanding your benefits and resolving any problems you may have, including:

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

Contacting Providence Customer Service
Customer Service representatives are available by phone from 8 a.m. to 5 p.m., Monday through Friday (excluding holidays). **Please have your Member ID Card available when you call:**

- **Members in the Portland-metro area, please call 503-574-7500.**
- **Members in all other areas, please call toll-free 800-878-4445.**
- **Members with hearing impairment, please call the TTY line 711.**

You may **access claims and benefit information 24 hours a day, seven days a week** online through your myProvidence account.

2.4 REGISTERING FOR A MYPROVIDENCE ACCOUNT

Members can create a myProvidence account online at myProvidence.com. A myProvidence account enables you to view your personal health plan information (including your Member Handbook and Benefit Summary), view claims history and benefit payment information, order a replacement Member ID Card, and access other health and wellness tools and services.

2.5 YOUR MEMBER ID CARD

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

- Your Member number and group number; and
- Important phone numbers.

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

Supplemental Benefits are any benefits purchased by your Employer in addition to your medical health care coverage (e.g., Prescription Drug, Massage Therapy, Vision, and Bariatric Surgery). Member ID Cards do not list your Supplemental Benefits. If your plan includes coverage for Supplemental Benefits, your Member materials will include information about each Supplemental Benefit in a Benefit Summary.

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

Please keep your Member ID Card with you and use it when you:

- Visit your health care provider or facility.
- Register online for your myProvidence account.
- Call for Mental Health/Substance Use Disorder Customer Service.
- Call or correspond with Customer Service.
- Call Providence RN medical advice line.
- Visit your pharmacy for prescriptions.
- Receive Immediate, Urgent or Emergency Care Services.

2.6 PROVIDENCE NURSE ADVICE LINE

503-574-6520; toll-free 800-700-0481; TTY 711

The Providence nurse advice line is a free medical advice line for Providence Health Plan Members. Available 24 hours a day, seven days a week, a registered nurse can answer your health-related questions.

Members often call the Providence nurse advice line when they have sick children, or when they have questions about how to treat flus, colds or backaches. After a brief message, a caregiver will ask you a few questions about why you're calling. A registered nurse will call you back to assist after reviewing your answers.

Please have your Member ID Card available when you call.

2.7 WELLNESS BENEFITS

Providence Health Plan members have access to the following wellness benefits:

- Providence Health Resource Line
  - Information on services, classes, self-help, smoking cessation and other services.
  - You can access by calling 503-574-6595 or 800-562-8964.
- Health education classes
  - Providence Health Plan Members may receive discounts on health education classes supporting smoking cessation, childbirth education and weight management.
  - You can access by calling the Providence Resource Line at 800-562-8964 or visiting providence.org/classes.
- Providence Health Coaching
  - Information on programs for weight loss, diabetes prevention, improving your diet, stress management and exercise.
  - You can access by calling 503-574-6000 (TTY: 711) or 888-819-8999 or visiting ProvidenceHealthPlan.com/healthcoach.
- Providence Health Plan Care Management
  - Access to highly skilled care teams who provide personalized education, navigation, and care coordination support for your health conditions, including asthma, cancer, diabetes, Mental Health, and more.
  - Ready to get started? Call 503-574-7247 or 800-662-1121 (TTY: 711) Monday through Friday, 8 a.m. to 5 p.m. (PST) or email Care.Management@Providence.org. Learn more at ProvidenceHealthPlan.com/CareManagement.
- Wellness information
  - You can find medical information, class information, information on extra values such as online tools and discounts and other information by visiting providence.org/healthplans.
- LifeBalance Program
  - Discounts on health, wellness, recreational and cultural activities.
  - You can access your LifeBalance program by calling 503-234-1375 or 888-754-LIFE or visiting LifeBalanceProgram.com.

- Travel Assistance Services,
    - Emergency logistical support to members traveling internationally or people traveling 100 miles from home.
    - Contact by calling 609-986-1234 or 800-872-1414 or visit assistamerica.com.
- Identity Theft Protection
    - Identity theft protection program for Providence Health Plan members.
    - Please call 614-823-5227 or 877-409-9597 or visit assistamerica.com/Identity-Protection/Login to sign up for the program; you will need your Health Plan Member ID number, and tell them your code is 01-AA-PRV-01193.

2.8 PRIVACY OF MEMBER INFORMATION

At Providence Health Plan, we respect the privacy and confidentiality of your protected health information (PHI). We are required by law to maintain the privacy of your protected health information, (commonly called PHI or your personal information) including in electronic format. When we use the term "personal information" we mean information that identifies you as an individual such as your name and Social Security Number, as well as financial, health and other information about you that is nonpublic, and that we obtain so we can provide you with insurance coverage. Providence Health Plan maintains policies that protect the confidentiality of personal information, including Social Security numbers, obtained from its Members in the course of its regular business functions.

Members may request to see or obtain their medical records from their provider. Call your physician's or provider's office to ask how to receive a copy.

For more information about uses and disclosures of Member information, including uses and disclosures required by law, please refer to our Notice of Privacy Practices. A copy is available at ProvidenceHealthPlan.com/nopp or by calling Customer Service.

Appointment of Authorized Representative

You are entitled to appoint an individual to act as your Authorized Representative to pursue any claim you have for benefits. To ensure privacy and to address other issues, Providence's policy on Appointment of Authorized Member Representatives, and the form for doing so, may be accessed through our website at ProvidenceHealthPlan.com/forms. The policy does not apply to an attorney at law retained by you directly to represent your interests with respect to your benefits, but does apply to attorneys who represent a medical service provider whose services are a part of the claim in issue.

Confidentiality and your Employer

In accordance with the federal privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), Providence Health Plan will not disclose a Member's protected health information (PHI) to the Employer or any agent of the Employer unless requested for the HIPAA allowed purpose of the Employer's obtaining bids from other health plans for further health coverage or for the Employer's modifying, amending, or terminating any benefit under the health plan.

Providence Health Plan may disclose a Member's PHI to an Employer or any agent of the Employer if the disclosure is:

1. In compliance with the applicable provisions of HIPAA; and
2. Due to a HIPAA-compliant authorization the Member has completed to allow the Employer access to the Member's PHI; or
3. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer. The details of this required certification can be reviewed at ProvidenceHealthPlan.com/nopp.

Providence Health Plan will disclose a Member's PHI with whom and in ways permitted by HIPAA. These uses are covered in detail in Providence Health Plan's Notice of Privacy Practices available online, or by mail if you request it.

3. HOW TO USE YOUR PLAN

Our goal is maintaining your health by promoting wellness and preventive care. This Plan requires assignment of a Primary Care Provider, who can provide most of your care, suggest specialist care and arrange for Hospital care or diagnostic testing.

This section describes how to use this Plan and how benefits are applied. It is important to remember that your benefits are determined according to the plan option that your Employer has elected and the kinds of Services and providers that you have selected for your care. The level of benefits for Covered Services is shown in the Benefit Summary and described in section 4 of this Member Handbook.

3.1 IN-NETWORK PROVIDERS

Providence Health Plan has contractual arrangements with certain physicians/providers, Hospitals and facilities located in our Service Area. Our agreements with these "In-Network Providers" enable you to receive quality health care for a reasonable cost.

For Services to be covered using your In-Network benefit, you must receive Services from In-Network Providers. It is your responsibility to verify whether or not a physician/provider, Hospital or other facility is an In-Network Provider even if you have been directed or referred for care by an In-Network Provider.

3.1.1 Nationwide In-Network Providers

Providence Health Plan also has contractual arrangements with certain Qualified Practitioners, Hospitals and facilities nationwide. These arrangements allow you to receive Services when using In-Network Providers even when you are outside the Providence Health Plan Service Area.

3.1.2 Choosing an In-Network Provider

<u>For Members with Signature Network coverage</u>

Members with Signature Network coverage, as listed in your Benefit Summary, may choose an In-Network Provider or verify if a provider is an In-Network Provider, by referring to the Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider. If you do not have access to our website, please call Customer Service to request In-Network Provider information.

<u>For Members with Extend PPO Network coverage</u>

Members with Extend PPO Network coverage, as listed in your Benefit Summary, may choose an In-Network Provider or verify if a provider is an In-Network Provider, by referring to the Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider. If you do not have access to our website, please call Customer Service to request In-Network Provider information.

Advantages of Using an In-Network Provider

- Your In-Network 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 3.5.
- In most cases when you use In-Network Providers, higher benefit levels will apply and your out-of-pocket expenses will be reduced.
- You will have a wide variety of high quality In-Network Providers to help you with your health care needs.

So remember, it is to your advantage to meet your health care needs by using an In-Network Provider, including an In-Network Primary Care Provider, whenever possible.

3.1.3 Indian Health Services Providers

Native American Indian and Alaskan Native Members may also access Covered Services from Indian Health Services (IHS) facilities at no greater cost than if the Services were accessed from an In-Network Provider. For a list of IHS facilities, please visit the IHS website at ihs.gov, or contact the regional IHS office at:

Portland Area Indian Health Service
1414 NW Northrup St., Ste. 800
Portland, OR 97209
Telephone: 503-414-5555

3.2 THE ROLE OF A PRIMARY CARE PROVIDER

To encourage optimum health, we promote wellness and preventive care. We also believe wellness and overall health is enhanced by working closely with one physician or provider – your Primary Care Provider. Your Primary Care Provider can provide most of your care and, when necessary, coordinate care with other providers in a convenient and cost-effective manner. We recommend you and each of your Family Members choose the In-Network Primary Care Provider that is right for you within 90 days of joining Providence Health Plan. Otherwise, we will assign one based on your location.

3.2.1 Primary Care Providers

A Primary Care Provider is a Qualified Practitioner who specializes in family practice, general practice, internal medicine, or pediatrics; a nurse practitioner; or a physician associate practicing in collaboration with a primary care physician. Members may choose and self-refer to a physician specializing in obstetrics or gynecology, a nurse practitioner, a certified nurse midwife, or a physician associate specializing in women's health care as their Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Primary Care Provider.

Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

Note: Not all Qualified Practitioners are Primary Care Providers. To obtain a listing of In-Network Primary Care Providers, please see the online Provider Directory or call Customer Service.

3.2.2 Established Patients with Primary Care Providers

If you and your family already see a provider, you may want to check the provider directory to see if your provider is an In-Network Primary Care Provider for Providence Health Plan. If your provider is participating with us, let his or her office know you are now a Providence Health Plan Member.

3.2.3 Selecting a New Primary Care Provider

This Plan requires assignment of a Primary Care Provider. If you do not select a Primary Care Provider for you and each of your Family Members within 90 days of coverage beginning, you will be assigned one in your area. To select a new Primary Care Provider, call the provider's office to make sure he or she is accepting new patients. It is a good idea to have your previous physician or provider transfer your medical records to your new Primary Care Provider as soon as possible. The first time you make an appointment with your Primary Care Provider, let him or her know you are now a Providence Health Plan Member. On your first visit, make a list of questions or information you would like to discuss with your new Primary Care Provider, including the following:

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

Let your Primary Care Provider know if you are under a specialist's care as well as if you are currently taking any ongoing prescription medications.

3.2.4 Changing Your Primary Care Provider

You are encouraged to establish an ongoing relationship with your Primary Care Provider. If you decide to change your Primary Care Provider, please remember to have your medical records transferred to your new Primary Care Provider.

3.2.5 Office Visits

Primary Care Providers

We recommend you see your Primary Care Provider for all routine care and call your Primary Care Provider first for urgent or specialty care. If you need medical care when your Primary Care Provider is not available, the physician/provider-on-call may treat you and/or recommend that you see another provider for treatment.

Specialists

Your Primary Care Provider will discuss with you the need for diagnostic tests or other specialist services; and may also recommend you see a specialist for treatment. You also may decide to see a specialist without consulting your Primary Care Provider. Visit the Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider, or call Customer Service to choose a specialist who is an In-Network Provider with Providence Health Plan.

If you decide to see a specialist on your own, we recommend you let your Primary Care Provider know about your decision. Your Primary Care Provider will then be able to coordinate your care and share important medical information with your specialist. In addition, we recommend you let your specialist know the name and contact information of your Primary Care Provider.

Whenever you visit a specialist:

- Bring your Providence Health Plan Member ID Card.
- Understand that in most cases, your out-of-pocket costs will be a percent of the charges for Services. Your provider's office will send you a bill for the amount you owe. Some providers, however, may ask you to pay an estimate of what you may owe at the time you receive Services, and will bill or credit you the balance later. (For certain Employer Group Plans, there is a Member Copayment for specialist visits instead of a Coinsurance. If you are on one of these Plans, you will need to pay your Member Copayment at the time of your visit. Please check your Benefit Summary for your specific coverage information.)

Alternative Care Providers

Your Plan includes coverage for office visits to naturopaths, chiropractors, and acupuncturists, as listed in your Benefit Summary. See section 14 for the definition of Alternative Care Provider. See section 14 for the definition of Alternative Care Provider. For coverage of chiropractic manipulation and acupuncture, see sections 4.12.14, 4.12.15 and your Benefit Summary.

3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS

You may choose to receive Covered Services from Out-of-Network Qualified Practitioners or facilities using your Out-of-Network benefit.

Benefits for Covered Services by an Out-of-Network Provider will be provided, as shown in the Benefit Summary. See section 3.5 Prior Authorization requirements.

Generally, when you receive Services from Out-of-Network Providers, your Copayments and Coinsurance will be higher than when you see In-Network Providers.

IMPORTANT NOTE: Your Plan only pays for Covered Services received from Out-of-Network Providers at Usual, Customary, and Reasonable rates (UCR) (see Section 14, Definitions). If an Out-of-Network Provider charges more than the UCR rates allowed under your Plan, that provider may bill you directly for the additional amount that is not covered by your Plan. That amount is in addition to any Deductible, Copayment, or Coinsurance for which you may be responsible, and does not accrue to your Out-of-Pocket Maximum.

If you choose to receive Covered Services from an Out-of-Network Provider, those Services are still subject to the terms of this Member Handbook. Providence Health Plan will only pay for Medically Necessary Covered Services. No matter what type of provider you see, the treatments, supplies, and medications excluded by this Plan are not covered.

If the provider you choose is Out-of-Network, it is important for you to understand that Providence Health Plan has not assessed the provider's credentials or quality, nor has Providence Health Plan reviewed and verified the Out-of-Network Provider's qualifications and history for information such as: relevant training, licensure, certification, and/or registration to practice in a health care field, and academic background. Additionally, the Out-of-Network Provider will not have been assessed by Providence Health Plan to verify that the provider meets certain criteria relating to professional competence and conduct and as such is not guaranteed to follow your benefit plan, rules, regulations, or guidelines with regard to standards of care nor standards of documentation and billing.

Some Services are only covered under your In-Network benefit:

- Tobacco Use Cessation Services (see section 4.1.8);
- Telehealth Services (see section 4.3.2);
- E-mail Visits (see section 4.3.3);
- Retail Health (see section 4.3.9);
- Temporomandibular Joint (TMJ) Services (see section 4.12.7);
- Human Organ/Tissue Transplants (see section 4.13);
- Prescription Drug Services (see section 4.11);
- Any Supplemental Benefit included in your Plan that is designated as In-Network only (see section 13); and
- Any item listed in your Benefit Summary as "Not Covered" under Out-of-Network.

Prescription Drugs must be purchased at one of our nationwide Participating Pharmacies (see section 4.14). A list of our Participating Pharmacies is available online at ProvidenceHealthPlan.com. You also may contact Customer Service if you need help locating a Participating Pharmacy near you or when you are away from your home. See your Benefit Summary for details on your Deductible, Copayment and Coinsurance, if applicable, and on how to use this benefit.

If you have a Bariatric Surgery Supplemental Benefit, Services are only available In-Network (see section 13.5).

Payment for Out-of-Network Physician/Provider Services (UCR)

After you meet your Deductible, if applicable, and if the Services provided are Medically Necessary Covered Services, we will provide payment to Out-of-Network Providers according to Usual, Customary and Reasonable (UCR) charges. UCR charges do not include sales taxes, handling fees and similar surcharges; such taxes, fees and surcharges are not covered expenses. Charges which exceed UCR are the Member's responsibility and are not applied to the Out-of-Pocket Maximum. See section 14 for the definition of UCR.

You will be responsible for costs that are not covered or allowed by your Out-of-Network benefits, as shown in the following example (amounts shown are only estimates of what may apply).

	Provider's Status	
Item	In-Network	Out-of-Network
Provider's standard charges	$100	$100
Allowable charges under this Plan	$80 (contracted)	$80 (if that is UCR)
Plan benefits (for this example only)	$64 (if 80% benefit)	$56 (if 70% benefit)
Balance you owe	$16	$24
Additional amount provider may bill to you	$-0-	$20 ($100 minus $80)
Total amount you would pay	$16	$44 ($24 plus $20)

Thus, you may incur significantly larger out-of-pocket costs, perhaps a multiple of what would have applied, if you use Out-of-Network Physicians or Providers.

Payment for Out-of-Network Provider Services with Network Access Exception

If there are no In-Network providers in your area, or if you require unique Medically Necessary skills or Services that are not available from any In-Network providers in your

area, you may request a Prior Authorization to be seen by an Out-of-Network provider or facility at the cost of your In-Network benefit. Allowable charges are based on UCR rates. These Services may be subject to review for Medical Necessity.

Payment for Covered Services Provided Before Disposition of Criminal Charges

If you are in the custody of an Oregon state or local corrections agency pending the disposition of criminal charges brought by an Oregon county, we will reimburse the custodial county for the costs of Covered Services or supplies rendered before the disposition of charges, in an amount that is no less than 115 percent of the Medicare rate for the Service or supply, except for renal dialysis which will be reimbursed in accordance with the terms of the Plan for Out-of-Network dialysis providers.

The following Services and Supplies are excluded from coverage under this section:

- Diagnostic tests or health evaluations required by the corrections agency, as a matter of course, for all individuals who are in the custody of the county pending the disposition of charges;
- Hospital and ambulatory surgical center services, except as rendered by an In-Network Provider.

3.3.1 Understanding Protections Against Surprise Medical Bills

When you get emergency care or get treated by an Out-of-Network Provider at an In-Network Hospital, Independent Freestanding Emergency Department or Ambulatory Surgical Center, you are protected by federal law from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a Copayment, Coinsurance, and/or a Deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-Network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-Network Providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than In-Network costs for the same service and might not count toward your annual Out-of-Pocket Maximum.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care—like when you have an emergency or when you schedule a visit at an In-Network facility but are unexpectedly treated by an Out-of-Network Provider.

You are protected from balance billing for:

Emergency Services

If you have an emergency medical condition and get Emergency Services from an Out-of-Network Provider or facility, the most the Provider or facility may bill you is your plan's In-Network cost-sharing amount (such as Deductibles, Copayments and Coinsurance). You cannot be balance billed for these Emergency Services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an In-Network Hospital, Independent Freestanding Emergency Department or Ambulatory Surgical Center
When you get services from an In-Network Hospital, Independent Freestanding Emergency Department or Ambulatory Surgical Center, certain Providers there may be Out-of-Network. In these cases, the most those Providers may bill you is your plan's In-Network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These Providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these In-Network facilities, Out-of-Network Providers cannot balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care Out-of-Network. You can choose a Provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

You are only responsible for paying your share of the cost (like the Copayments, Coinsurance, and Deductibles that you would pay if the provider or facility was In-Network). Your health plan will pay Out-of-Network Providers and facilities directly.

Your health plan generally must:

- Cover Emergency Services without requiring you to get approval for services in advance (Prior Authorization).
- Cover Emergency Services by Out-of-Network Providers.
- Base what you owe the Provider or facility (cost-sharing) on what it would pay an In Network Provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for Emergency Services or Out-of-Network services toward your Deductible and Out-of-Pocket Maximum.

If you believe you've been wrongly billed, you may contact Providence Health Plan Customer Service from 8:00 a.m. to 5:00 p.m. PST at 503-574-7500 or 1-800-888-8888, for hearing impaired call 711.

For assistance outside of Providence Health Plan:

- State
  You may contact the Oregon Division of Financial Regulation at: Oregon Division of Financial Regulation, Consumer Protection Unit at 503-947-7984 or 1-888-877-4894, or visit https://dfr.oregon.gov.
- Federal
  You may contact the U.S. Department of Health and Human Services and file a complaint by calling 800-985-3059 (toll-free) or going to https://www.cms.gov/nosurprises/consumers.

3.4 NOTICE OF PROVIDER TERMINATION

When an In-Network Provider whose contract of participation with us terminates, we will notify those Members who we know are under the care of the terminated provider within 10 days of the termination date or of our knowledge of the termination date.

3.5 PRIOR AUTHORIZATION

While Prior Authorization is a requirement for coverage of certain Services under this Plan, Prior Authorization is not a treatment directive. The actual course of medical treatment that a Member chooses remains strictly a matter between the Member and the provider and is separate from the Prior Authorization requirements of this Plan. Prior Authorization is not a guarantee of benefit payment under this Plan and a Prior Authorization determination does not supersede other specific provisions of this Plan regarding coverage, limitations, exclusions and Medical Necessity.

Services received from In-Network Providers:
When Services are received from an In-Network Provider, the In-Network Provider is responsible for obtaining Prior Authorization.

Services received from Out-of-Network Providers:
When Services are received from an Out-of-Network Provider, the Member is responsible for obtaining Prior Authorization. You or your Out-of-Network Provider must contact us to obtain Prior Authorization. See section 3.3 for additional information about Out-of-Network Providers.

Services requiring Prior Authorization:
A comprehensive list of services and supplies that must be Prior Authorized is available by visiting our website at ProvidenceHealthPlan.com/PriorAuthorization. You may also contact Customer Service to inquire whether a service or supply requires Prior Authorization. You or your Provider should submit Prior Authorization requests by following the instructions on our website. We will not require Prior Authorization for services and supplies that by law do not require Prior Authorization, including Emergency Room services.

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 Member ID card.

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

Prior Authorization Requests for Out-of-Network Services:
The Member or the Out-of-Network Provider must call us at 800-638-0449 to obtain Prior Authorization. Please have the following information ready when calling to request a Prior Authorization:

- The Member's name and date of birth.
- The Member's Providence Health Plan Member number and Group number (these are listed on your Member ID card).
- The Provider's name, address and telephone number.
- The name of the Hospital or treatment facility.

- The scheduled date of admission or date Services are to begin.
- The Service(s) to be performed.

Failure to Obtain Prior Authorization:
If you do not obtain Prior Authorization for Services received from an Out-of-Network Provider, as specified in section 3.3, a 50% **penalty,** not to exceed $2,500 for each Covered Service, will be applied to the claim. Should we determine that we would have covered the Service had Prior Authorization been obtained, benefits will be applied to the remaining claim balance after the Prior Authorization Penalty is assessed. The **penalty** does **NOT** apply to the Deductible, if any, or to the Out-of-Pocket Maximum shown in the Benefit Summary. The penalty also does NOT apply to Mental Health or Substance Use Disorder Services.

3.6 TRAVEL EXPENSE REIMBURSEMENT

Subject to Prior Authorization, if you are unable to locate an In-Network Provider to provide Medically Necessary Covered Services for your specific condition within 50 miles of your home, the Plan will reimburse your travel expense to the nearest In-Network Provider within 300 miles of your home. Reimbursement will be based on the federal medical mileage reimbursement rate in effect on the date of service. Travel expense reimbursement is limited to $1,500 per Calendar Year. If an overnight stay is required, food and lodging are reimbursable up to $150 per diem (per day). Per diem expenses apply to the $1,500 travel expenses reimbursement maximum.

Note: Transplant Covered Services include a separate travel expense benefit; see section 4.13.1.

3.7 MEDICAL COST MANAGEMENT

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

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

We reserve the right to make substitutions for Covered Services under this Plan. A substituted Service must:

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

The Plan's coverage of a Substituted Service for any Member does not obligate Providence Health Plan to:

- Cover a Substituted Service for any other Member;
- Continue to cover a Substituted Service beyond the term of the agreement between Providence Health Plan and the Member; or
- Cover any Substituted Service for the Member, other than as specified in the agreement between Providence Health Plan and the Member.

Substituted Services that satisfy the requirements of this section are Covered Services for all purposes under this Plan.

We may disallow a Substituted Service at any time by sending a 30-day advance written notice to you and your Qualified Practitioner.

3.7.1 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 Providence Health Plan through review of trend reports from technology assessment bodies, government publications, medical journals, and information provided by providers and professional societies.

A systematic process for evaluating a new technology or new application of an existing technology is proactively initiated when sufficient scientific information is available.

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 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 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 7.

3.8 MEDICALLY NECESSARY SERVICES

We believe you are entitled to comprehensive medical care within the standards of good medical practice. Our medical directors and special committees of In-Network Providers determine which Services are Medically Necessary, as defined in section 14. Services that do not meet Medically Necessary criteria will not be covered.

- ***Example:*** *Your provider suggests a treatment using a machine that has not been approved for use in the United States. We probably would not pay for that treatment.*
- ***Example:*** *You go to a hospital emergency room to have stitches removed, rather than wait for an appointment in your doctor's office. We would not pay for that visit.*
- ***Example:*** *You stay an extra day in the Hospital only because the relative who will help you during recovery can't pick you up until the next morning. We may not pay for the extra day.*

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

3.9 APPROVED CLINICAL TRIALS

Benefits are provided for Covered Services directly related to a Member's participation in an Approved Clinical Trial. If your Approved Clinical Trial is available through both In-Network and Out-of-Network Providers, Providence will require you to participate through an In-Network Provider.

Covered Services include the routine patient costs for items and Services received in connection with the Approved Clinical Trial, to the extent that the items and Services are otherwise Covered Services under the Plan.

The following costs are excluded:

- The cost of the investigational item, device or service;
- The cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management; and
- The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

The Plan does not discriminate against a Member who participates in a clinical trial, whether or not the trial is an Approved Clinical Trial. The Plan provides benefits for Services unrelated to a clinical trial to the extent that the Services are otherwise Covered Services under the Plan.

3.10 HOW BENEFITS ARE APPLIED

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

- The Deductible;
- The Copayment or Coinsurance amount; and
- The benefit limits and/or maximums.

3.11 DEDUCTIBLES, OUT-OF-POCKET MAXIMUMS AND THE ANNUAL LIMIT ON COST-SHARING

Most Plans have a Deductible. If your Plan has a Deductible, it will be stated in your Benefit Summary.

Most Plans have an Out-of-Pocket Maximum. If your Plan has an Out-of-Pocket Maximum, it will be stated in your Benefit Summary.

Deductible amounts apply to Out-of-Pocket Maximums.

3.11.1 Understanding Deductibles

Your Deductible is the dollar amount you must pay each Calendar Year before we provide benefits for Covered Services. Deductible amounts are payable to your Qualified Practitioner after we have processed your claim.

Certain Covered Services are covered without meeting the Deductible, including Core Preventive drugs, subject to formulary tier, and most In-Network preventive care. Please see your Benefit Summary for more information.

Deductibles can be Common, shared between In-Network and Out-of-Network benefits; or Separate, a different Deductible for In-Network vs. Out-of-Network benefits.

Deductibles can be Aggregate, applying to all members or Embedded, applying to each Member.

Aggregate and Embedded Deductibles can be Common or Separate.

Common In-Network and Out-of-Network Deductible: If your Plan has a **Common Deductible**, it will be listed in your Benefit Summary. **A Common Deductible applies to both In-Network and Out-of-Network benefits.** The Common Deductible can be met by using In-Network or Out-of-Network benefits, or a combination of both.

Separate In-Network and Out-of-Network Deductibles: If your Plan has **Separate Deductibles**, it will be listed in your Benefit Summary. Your In-Network Deductible applies to Covered Services received using your In-Network Benefit, and your Out-of-Network Deductible applies to Covered Services received using your Out-of-Network benefit. **These In-Network and Out-of-Network Deductibles accumulate separately and are not combined.**

Aggregate Deductibles:

- ***Individual Deductible:*** An Individual Deductible is the amount shown in the Benefit Summary that applies when only one Member is enrolled in this Plan, and is the amount that must be paid by the Member before the Plan provides benefits for Covered Services for that Member.
- ***Family Deductible:*** The Family Deductible is the amount shown in the Benefit Summary that applies when two or more Family Members are enrolled in this Plan, and is the amount that must be paid before the Plan provides benefits for any enrolled Family Members. All amounts paid by Family Members toward Covered Services apply toward the Family Deductible. When the Family Deductible is met, the Plan will begin paying for Covered Services for all enrolled Family Members.

Embedded Deductibles:

- ***Individual Deductible:*** An Individual Deductible is the amount shown in the Benefit Summary that applies regardless of how many members are enrolled, and is the amount that must be paid by the Member before the Plan provides benefits for Covered Services for that Member.
- ***Family Deductible:*** The Family Deductible is the amount shown in the Benefit Summary that applies when two or more Family Members are enrolled in this Plan, and is the maximum Deductible that enrolled Family Members must pay. All amounts paid by Family Members toward their Individual Deductibles apply toward the Family Deductible. When the Family Deductible is met, no further Individual Deductibles will need to be met by any enrolled Family Members.
- Note: No Member will ever pay more than an Individual Deductible before the Plan begins paying for Covered Services for that Member.

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

- 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;
- Any penalties you must pay if you do not follow Providence Health Plan's Prior Authorization requirements; and
- Copayments or Coinsurance specified as not applicable toward the Deductible in any Benefit Summary issued with this Plan.

3.11.2 Understanding Out-of-Pocket Maximums

Out-of-Pocket Maximums are the total amount you will pay out-of-pocket in any Calendar Year for Covered Services received under this Plan. See your Benefit Summary.

Out-of-Pocket Maximums can be Common, shared between In-Network and Out-of-Network benefits; or Separate, a different Out-of-Pocket Maximum for In-Network vs. Out-of-Network benefits.

Out-of-Pocket Maximums can be Aggregate, applying to all members; or Embedded, applying to each Member.

Common In-Network and Out-of-Network Out-of-Pocket Maximum: Your plan has a Common In-Network and Out-of-Network Out-of-Pocket Maximum as listed in your Benefit Summary. The Common Out-of-Pocket Maximum can be met by payments you make for Covered Services using In-Network and Out-of-Network benefits.

Separate In-Network and Out-of-Network Out-of-Pocket Maximums: If your Plan has Separate In-Network and Out-of-Network Out-of-Pocket Maximums, it will be listed in your Benefit Summary. Your In-Network Out-of-Pocket Maximum can be met by payments you make for Covered Services received using your In-Network benefit, and your Out-of-Network Out-of-Pocket Maximum can be met by payments you make for Covered Services received using your Out-of-Network benefit. **These In-Network and Out-of-Network Out-of-Pocket Maximums accumulate separately and are not combined**.

Aggregate Out-of-Pocket Maximums:

- ***Individual Out-of-Pocket Maximum:*** An Individual Out-of-Pocket Maximum applies when only one Member is enrolled in the Plan, and means the total amount of Copayments, Coinsurance and Deductible that the Member must pay in a Calendar Year, as shown in the Benefit Summary, before the Plan begins to pay 100% for Covered Services for that Member within that Calendar Year.
- ***Family Out-of-Pocket Maximum:*** The Family Out-of-Pocket Maximum applies when two or more Family Members are enrolled in the Plan, and means the total amount of Copayments, Coinsurance and Deductible that a family must pay in a Calendar Year, as shown in the Benefit Summary, before the Plan begins to pay 100% for Covered Services for enrolled Family Members. The Family Out-of-Pocket Maximum can be met by the combined expenses of enrolled Family Members. Once the Family Out-of-Pocket Maximum is met, the Plan will begin to pay 100% for Covered Services for enrolled Family Members within the Calendar Year.
- Note: Only Member expenses for Covered Services can be used to meet your Individual and Family Out-of-Pocket Maximums.

Embedded Out-of-Pocket Maximums:

- ***Individual Out-of-Pocket Maximum:*** An Individual Out-of-Pocket Maximum means the total amount of Copayments, Coinsurance and Deductible that the Member must pay in a Calendar Year, as shown in the Benefit Summary, before the Plan begins to pay 100% for Covered Services for that Member within that Calendar Year.
- ***Family Out-of-Pocket Maximum:*** The Family Out-of-Pocket Maximum means the total amount of Copayments, Coinsurance and Deductible that a family of two or more must pay in a Calendar Year, as shown in the Benefit Summary, before the Plan begins to pay 100% for Covered Services for enrolled Family Members. When the combined Copayment, Coinsurance and Deductible expenses of 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 Member meets the Individual Out-of-Pocket Maximum, the Plan will begin to pay 100% for Covered Services for that Member.

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

- Services not covered by this Plan;
- Services not covered because Prior Authorization was not obtained, as required in section 3.5;
- Services in excess of any maximum benefit limit;
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges;
- Deductibles, Copayments or Coinsurance amounts for Adult Vision;
- Deductibles, Copayments or Coinsurance for a Covered Service if indicated in any Benefit Summary as not applicable to the Out-of-Pocket Maximum; and
- Any penalties you must pay if you do not follow Providence Health Plan's Prior Authorization requirements.

IMPORTANT NOTE: Supplemental Benefits are NOT eligible for 100% benefit coverage. The Copayment or Coinsurance for these Services, as shown in the Supplemental Benefit Summary, remains in effect throughout the Calendar Year.

3.11.3 Understanding the Annual Limit on Cost-Sharing

The Annual Limit on Cost-Sharing and Plans with Embedded Out-of-Pocket Maximums:
On Plans with Embedded Out-of-Pocket Maximums, the In-Network Individual Out-of-Pocket Maximum serves as the Annual Limit on Cost-Sharing unless the Out-of-Pocket Maximum is less than the Annual Limit on Cost-Sharing.

The Annual Limit of Cost-Sharing and Plans with Aggregate Out-of-Pocket Maximums:
On Plans with Aggregate Out-of-Pocket Maximums, the Annual Limit on Cost-Sharing is the maximum out-of-pocket expense that a Member enrolled on a Family Plan must pay in a Calendar Year for In-Network Essential Health Benefit Covered Services unless the Out-of-Pocket Maximum is less than the Annual Limit on Cost-Sharing.

All In-Network Deductible, Copayment and Coinsurance amounts paid by the Member for Essential Health Benefit Covered Services apply to the Annual Limit on Cost-sharing. Once the Annual Limit on Cost-Sharing is met by a Member, the Plan will pay 100% for In-Network Essential Health Benefit Covered Services for that Member.

An Annual Limit on Cost-Sharing is separate from an Out-of-Pocket Maximum, and can only be met by Member costs for In-Network Covered Services that qualify as Essential Health Benefits. Essential Health Benefits encompass 10 broad categories:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental Health and Substance Use Disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including dental and vision care.

Not all Services covered under the Plan qualify as Essential Health Benefits. If a Service does not qualify, it will not accumulate to the Annual Limit on Cost-Sharing and will be labeled as such in your Benefit Summary.

No costs for Covered Services received Out-of-Network apply to the Annual Limit on Cost-Sharing.

Member costs applied to the Annual Limit on Cost-Sharing will also apply to the In-Network Out-of-Pocket Maximum.

Your Costs that Do Not Apply to the Annual Limit on Cost-Sharing: **The following out-of-pocket costs do not apply towards the Annual Limit on Cost-Sharing:**

- Services that do not qualify as Essential Health Benefits;
- Services not covered by this Plan;
- Services in excess of any maximum benefit limit;
- Deductibles, Copayments or Coinsurance amounts for Adult Vision;
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges;
- Premiums and penalties; and
- Any costs you must pay if you do not follow Providence Health Plan's Prior Authorization Requirements.

4. COVERED SERVICES

This section describes Services that, when Medically Necessary and not otherwise excluded or limited, are covered under this Plan. Your covered benefits are determined by the contract your Employer Group has entered into with Providence Health Plan.

Benefits and Plan provisions such as Deductibles, Copayments, Coinsurances and Out-of-Pocket Maximums vary among Employer Groups. Please refer to your Benefit Summary for details of your specific coverage. You can view your Member materials by registering for a myProvidence account on our website at ProvidenceHealthPlan.com (see section 2.4). If Providence Health Plan is required by law to modify your benefits, you will be notified in writing of the changes.

This Plan provides coverage of Essential Health Benefits as required by the Patient Protection and Affordable Care Act and related legislation. See section 14 for the definition of Essential Health Benefits.

Benefits are provided for preventive care and for the treatment of illness or injury when such treatment is Medically Necessary and provided by a Qualified Practitioner, as described in this section and shown in the Benefit Summary.

4.1 PREVENTIVE SERVICES

Preventive Services are covered, as shown in the Benefit Summary. For Women's Preventive Health Care Services, see section 4.2.

In accordance with the Patient Protection and Affordable Care Act of 2010 and related legislation, your Plan covers the following Services in full when received from In-Network Providers:

- Services rated "A" or "B" by the U.S. Preventive Services Task Force, https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children and adolescents as supported by the Health Resources and Services Administration; and
- Preventive care and screenings for women as supported by the Health Resources and Services Administration, http://hrsa.gov/womens-guidelines/.

Note: Additional Plan provisions apply to some Services (e.g., to be covered in full, routine physical examinations and well-baby care must be received from an In-Network Provider, see section 4.1.1). If you need assistance understanding coverage for preventive Services under your Plan, please contact Customer Service at 503-574-7500.

4.1.1 Physical Examinations and Well-Baby Care

Periodic health exams and well-baby care Services are covered in full only when received In-Network. These Services are covered, as stated in your Benefit Summary. Your provider will determine which tests are necessary for your physical exam according to your medical history and your current health status. More frequent exams will be covered if your provider determines that they are necessary. Vision and hearing screening Services are covered

when performed during a periodic health examination or well-baby care examination. In order for a child to be eligible for benefits for routine newborn baby care, the child must be properly enrolled as outlined in section 8. Ancillary Services, such as immunizations, are covered at the specified benefit level when billed by the provider.

Recommended Guidelines:	
Infants up to 30 months:	Up to 12 well-baby visits.
Children and Adolescents:	
3 years through 21 years:	One exam every year.
Adults:	
22 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.

If, at the time of your routine physical examination or well-child care, you need paperwork completed for a third party, such as school, camp, team sports, etc., your provider may charge you a fee to complete the paperwork. We will not cover this additional fee.

4.1.2 Immunizations and Vaccinations

Benefits for immunizations and vaccinations are provided in accordance with accepted medical practice. Visits to your Qualified Practitioner's office or Participating Pharmacy for immunizations or injections are subject to the Copayment or Coinsurance shown in the Benefit Summary. Some immunizations may require Prior Authorization, as listed in the Medical benefit drug prior authorization list available on our website at ProvidenceHealthPlan.com/pharmacy or by calling Customer Service.

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

4.1.3 Prostate Cancer Screening Exams

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

4.1.4 Colorectal Cancer Screening Exams

Benefits for colorectal cancer screening examinations for Members age 45 and older include:

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

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

For Members age 45 and older:

- In-Network: All Services for colorectal cancer screenings and exams are covered in full, including prescription drug bowel prep kits, as listed in our formulary.
- Out-of-Network: All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery Benefit. Fecal occult blood test and double contrast barium enemas are covered under the Lab Services benefit.

For Members under age 45:

- In-Network and Out-of-Network: All colonoscopy and sigmoidoscopy Services are covered under the Outpatient Surgery Benefit. Fecal occult blood tests and double contrast barium enemas are covered under the Lab Services benefit.

For all Members, non-preventive colonoscopy and sigmoidoscopy procedures provided to treat health conditions (injury, illness or disease) are covered under your Outpatient patient benefits, as shown in your Benefit Summary.

4.1.5 Preventive Services for Members with Diabetes

Preventive Covered Services for Members diagnosed with either insulin dependent or non-insulin dependent diabetes mellitus include:

- A dilated retinal exam by a qualified eye care specialist every Calendar Year;
- A glycosylated hemoglobin (HbA1c) test, a urine test to test kidney function, blood test for lipid levels as appropriate, a visual exam of mouth and teeth (dental visits are not covered), foot inspection, and influenza vaccine by a Qualified Practitioner every Calendar Year; and
- A pneumococcal vaccine every five years.

4.1.6 Diabetes Self-Management Education Program

Benefits are paid in-full for diabetes self-management education programs associated with the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes as prescribed by a Qualified Practitioner. “Diabetes self-management program” means one program of assessment and training after diagnosis as well as assessment and training upon a material change of condition, medication or treatment. All Services must be received from licensed providers and facilities, practicing within scope of license.

4.1.7 Nutritional Counseling

Nutritional counseling is covered when Medically Necessary, as shown in your Benefit Summary. Fasting and rapid weight loss programs are not covered.

4.1.8 Tobacco Use Cessation Services

Coverage is provided for participation in a Providence Health Plan-approved, physician-recommended tobacco use cessation program that follows the United States Public Health Service guidelines. “Tobacco use cessation program” includes educational and medical treatment components, such as, but not limited to, counseling, classes, nicotine replacement therapy and prescription drugs designed to assist Members in ceasing the use of tobacco products. A list of Providence Health Plan-approved programs is available by calling Customer Service at 503-574-7500 or 800-878-4445 and online at ProvidenceHealthPlan.com (select “search” and enter “tobacco cessation”).

4.2 WOMEN'S PREVENTIVE HEALTH CARE SERVICES

Women may choose to receive Women's Preventive Health Care Services from a Primary Care Provider or a Women's Health Care Provider without a referral. Women's Health Care Providers include physicians specializing in obstetrics, some Primary Care Providers and naturopaths (if they are licensed to provide the Services), physician associates and nurse practitioners specializing in women's health care, certified nurse midwives and licensed direct entry midwives.

4.2.1 Gynecological Examinations

Benefits for gynecological examinations include breast, pelvic and Pap examinations once every Calendar Year or more frequently for women who are designated high risk. Family Planning Services are separate (see section 4.2.4). Benefits also include follow-up exams for any medical conditions discovered during an Annual gynecological exam that require additional treatment.

4.2.2 Mammograms

Mammograms are covered for women 40 years of age and over once every Calendar Year. If the Member is designated high risk, mammograms are covered as recommended by the Qualified Practitioner or Women's Health Care Provider. See section 4.4.3 for diagnostic and supplemental breast examinations.

4.2.3 Breastfeeding Counseling and Support

Coverage for lactation counseling is provided when Medically Necessary and performed by a Qualified Practitioner. Benefits include coverage in full for breast pump equipment and supplies when rented or purchased through our In-Network Medical Equipment Providers. Out-of-Network, coverage is subject to your Durable Medical Equipment (DME) benefits.

4.2.4 Family Planning Services

Benefits include counseling, exams, and Services for voluntary family planning.

Services and supplies are covered as required by the Patient Protection and Affordable Care Act of 2010 and related legislation; and include, but are not limited to:

- Intrauterine device (IUD) insertion and removal;
- Medical exams and consultation for family planning;
- Depo-Provera to prevent pregnancy;
- Diaphragm devices;
- Removal of implantable contraceptives;
- Oral contraceptives (birth control pills) listed in our Formulary. FDA approved women's prescription contraceptives: up to 3-months initial dispensing, then up to 12-months subsequent dispensing at any Participating Pharmacy; and
- Over-the-counter contraceptive drugs, devices, and products approved by the federal Food and Drug Administration.

All Covered Services must be received from Qualified Practitioners and Facilities or purchased from Participating Pharmacies.

- In-Network: Services are covered in full.
- Out-of-Network: Services are covered subject to the provisions of the applicable Out-of-Network benefit, e.g., IUDs and diaphragms are covered under your medical supply benefit.

If you self-pay (without insurance) for over-the-counter contraceptives, you can submit a request for reimbursement. Please visit ProvidenceHealthPlan.com/Members/Pharmacy-Resources for more information.

For coverage of tubal ligation, see Elective Sterilization, section 4.12.9.

4.3 PROVIDER SERVICES

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

Office visits, inpatient and outpatient hospital visits and home visits with a Qualified Practitioner are covered, as shown in your Benefit Summary. Copayments and Coinsurances, as shown in your Benefit Summary, apply to all provider visits except those that: (a) are part of a course of maternity care; (b) are for conditions for which this Plan contains a separate and specific Copayment or Coinsurance amount; or (c) are ancillary to the visit and are billed by the Qualified Practitioner. Some Services provided by your Qualified Practitioner during your visit may result in additional Member financial responsibility.

For example – You see your Primary Care Provider for an office visit and during your visit your provider swabs your throat for a throat culture. You would pay your office visit Copayment or Coinsurance and would also need to pay the Laboratory Services Copayment or Coinsurance for the throat culture. See your Benefit Summary for details.

Your Benefit Summary also lists different Copayments or Coinsurance that may apply for other specific Services, such as allergy shots, maternity care, and diagnostic services. See your Benefit Summary for details.

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

4.3.2 Telehealth Services

Telehealth services are services delivered through a variety of web-based or telecommunication technologies. The plan covers Telehealth services, when medically necessary and generally accepted healthcare practices and standards determine they can be safely and effectively provided using web-based or telecommunication technologies.

4.3.2.1 On-Demand Virtual Visits

Visits using a dedicated branded, web-based platform (such as Providence ExpressCare Virtual) through a tablet, smartphone, or computer for same-day appointments with a healthcare provider. Benefits will apply, as shown in your Benefit Summary.

4.3.2.2 Office Visits Virtually

Scheduled visits with the member's PCP or Specialist using a teleconferencing application such as Zoom. Benefits will apply, as shown in your Benefit Summary.

4.3.2.3 Telemedicine Services

Telemedicine Services are covered at the applicable benefit level for the Covered Service, as shown in the Benefit Summary, had the Service been received in person provided that the Service:

- Is Medically Necessary;
- Is provided by a Qualified Practitioner;
- Is determined to be safely and effectively provided using synchronous or asynchronous transmissions using audio only, video only, audio and video and transmission of data from remote monitoring devices; and
- The application and technology used to provide the Telemedicine Service meet all standards required by state and federal laws governing the privacy and security of protected health information.

For Members utilizing Telemedicine Services for the treatment of diabetes where one of the participants is a representative of an academic health center, coverage is provided when Services are delivered through a two-way electronic communication. This includes, but is not limited to, video, audio, Voice over Internet Protocol, or transmission of telemetry, that allows a health professional to interact with the Member, a parent or guardian of a Member or another health professional on a Member's behalf, who is at an originating site.

4.3.3 E-mail Visits

E-mail Visits are covered in full once your Deductible has been met and must be received from In-Network Providers; for qualifying preventive E-mail Visits, the Deductible is waived. Not all In-Network Providers offer E-mail Visits. Medical doctors (M.D.), doctors of osteopathy (D.O.), nurse practitioners (N.P.) and physician associates (P.A.) are the only categories of providers who may be approved for E-mail Visits. In-Network Providers who are authorized to provide E-mail Visits have agreed to use Internet security technology approved by us to protect your information from unauthorized access or release. To be eligible for the E-mail Visit benefit, you must have had at least one prior office visit with your In-Network Provider within the last 12 months.

Covered E-mail 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 us;
- Communications by the In-Network 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-mail 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;
- A brief discussion to confirm stability of a chronic problem and continuity of present management of the problem; and
- All communications in connection with Mental Health or Substance Use Disorder Covered Services, as provided in section 4.10.

4.3.4 Telephone Visits

Plan covers scheduled audio-only Office Visits for patients with an In-network Provider.

4.3.5 Allergy Shots and Allergy Serums

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

4.3.6 Injectable and Infused Medications

Injectable and infused medications received in your Provider's office are covered, as shown in your Benefit Summary. Some injectable medications may require Prior Authorization, as listed in the Medical benefit drug Prior Authorization list available at ProvidenceHealthPlan.com/pharmacy or by calling Customer Service. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. See section 4.7.1 for coverage of infusion at Outpatient Facilities.

4.3.7 Administration of Anesthesia and Surgical Procedures

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

4.3.8 Immediate Care

Immediate Care is an extension of your Primary Care Provider's office, and provides additional access to treatment you need right away for an illness or injury that is not life threatening. This includes, but is not limited to, minor sprains, minor cuts and burns, and ear, nose, and throat infections. Routine care, like periodic health exams and well-baby care, should be delayed until you can be seen by your Primary Care Provider.

Whenever you need immediate care, call your Primary Care Provider first. Your Primary Care Provider or the provider-on-call is always available, day or night. He or she may either

suggest that you be seen at your Primary Care Provider's office or direct you to an immediate care center, Urgent Care or emergency care facility. See section 4.5 for coverage of Emergency Care and Urgent Care Services.

Please be prepared to pay the Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are also responsible for the applicable Copayment/Coinsurance shown in the Benefit Summary for any ancillary Services received, such as lab tests and X-rays, billed by the Immediate Care Provider.

4.3.9 Retail Health Clinic

Coverage is provided, as shown in the Benefit Summary for Covered Services obtained at Retail Health Clinics. Retail Health Clinics can provide diagnosis and treatment Services for uncomplicated minor illnesses and injuries, like sore throats, ear aches, and sprains. Routine care, like periodic health exams and well-baby care, should be delayed until you can be seen by your Primary Care Provider. All Covered Services must be Medically Necessary and appropriate and received from Qualified Practitioners. Not all services are available at Retail Health Clinics.

4.4 DIAGNOSTIC SERVICES

Coverage is provided, as shown in your Benefit Summary for Diagnostic Services.

4.4.1 Diagnostic Pathology, Radiology Tests, High-Tech Imaging and Diagnostic Procedures

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

4.4.2 Sleep Study Services

Benefits include coverage of Medically Necessary polysomnography (PSG). PSG is an overnight sleep test performed at home or in a sleep laboratory. The test is used to confirm a sleep disorder and to determine the appropriate treatment. Services must be Prior Authorized.

The following diagnostics are excluded: actigraphy, daytime nap polysomnography, cephalographic or tomographic X-rays for diagnosis or evaluation of an oral device, and acoustic pharyngometry.

4.4.3 Diagnostic and Supplemental Breast Examinations

Coverage is provided for diagnostic and supplemental breast examinations. Diagnostic breast exams are used to evaluate an abnormality of the breast that is detected or suspected from a screening examination for breast cancer or by any other means of examination using diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound.

Supplemental breast examinations include breast magnetic resonance imaging or a breast ultrasound. These exams are used to screen for breast cancer when there is no abnormality

seen or suspected but there is an increased risk of breast cancer based on personal or family medical history or other factors.

See section 4.2.2 for annual preventive mammograms.

4.5 EMERGENCY CARE AND URGENT CARE SERVICES

Benefits for Emergency Care and Urgent Care Services are provided as described below and shown in your Benefit Summary. Emergency Care Services are provided both in and out of the Service Area. 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.

4.5.1 Emergency Care

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

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

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 in order for coverage to continue.

Definitions:

"Emergency Medical Condition" is a medical condition or behavioral health condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to severe pain, that a prudent layperson, possessing an average knowledge of health and medicine, would reasonably expect that failure to receive immediate medical or behavioral health attention would:

- Result in serious impairment to bodily functions;
- Result in serious dysfunction of any bodily organ or part;
- Place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy;
- With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another Hospital before delivery or for which transfer may pose a threat to the health or safety of the woman or the unborn child; or
- That is a behavioral health crisis.

"*Emergency Services"* means, with respect to an Emergency Medical Condition:

- A medical screening exam, or behavioral health assessment that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition;

- Such further medical examination and treatment as are required under the Emergency Medical Treatment and Active Labor Act (42 U.S.C. 1395dd) to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at the Hospital or Independent Freestanding Emergency Department; and
- Covered Services provided by staff or facilities of a Hospital or Independent Freestanding Emergency Department after the Member is stabilized and as part of outpatient observation or an inpatient or outpatient stay, including post-stabilization services for medical or behavioral health conditions that is Medically Necessary to avoid placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Your Plan covers Emergency Services in the emergency room of any Hospital or Independent Freestanding Emergency Department.

If you or a Family Member believes that immediate assistance is needed for an Emergency Medical Condition, **call 911 or go to the nearest emergency room**. Tell the emergency personnel the name of your Primary Care Provider and show them your Member ID Card.

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

Please be prepared to pay your Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are responsible for the Copayment/Coinsurance for each hospital emergency room visit.

If you are admitted to the Hospital from the emergency room, your emergency Services Copayment/Coinsurance does not apply and all Services are subject to the Inpatient Services benefit shown in your Benefit Summary.

When you are admitted to an Out-of-Network Hospital from the emergency room, your Inpatient Services are covered under your In-Network benefit until your condition becomes stable. Once your condition is stabilized, Providence Health Plan will work with you to arrange transfer to an In-Network facility. This process is called “repatriation.”

Costs for non-emergency medical transport to facilitate repatriation to an In-Network facility are covered in full.

If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will be subject to your Out-of-Network benefits.

The Plan does not pay for emergency room treatment for medical conditions that are not medical emergencies. Do not go to the emergency room for care that should take place in your provider’s office. Routine care for sore throats, common colds, follow-up care, and prescription drug requests are not considered to be emergencies.

4.5.2 Emergency Medical Transportation

Benefits include Services for emergency medical transportation by state certified ambulance and certified air ambulance transportation. Ambulance Services are provided for transportation to the nearest facility capable of providing the necessary emergency care or to a facility specified by Providence Health Plan. Air ambulance transportation is only covered for a life-threatening medical emergency, or when ground ambulance is either not available or would cause an unreasonable risk of harm because of increased travel time. Ambulance transportation solely for personal comfort or convenience is not covered.

4.5.3 Emergency Eye Care Services

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

4.5.4 Emergency Detoxification Services

Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a Substance Use Disorder treatment program, as stated in section 4.10.3, at the time Services are received. Prior Authorization is not required for emergency treatment; however, we must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to an In-Network Provider for continued inpatient care, the cost of Medically Necessary transportation will be covered.

4.5.5 Urgent Care

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

Whenever you need Urgent Care, call your Primary Care Provider first. Your Primary Care Provider or the provider-on-call is always available, day or night. He or she may either suggest that you come to the office or go to an emergency room or urgent care center. If you can be treated in your provider's office or at an In-Network urgent care center your out-of-pocket expense will usually be lower.

Please be prepared to pay the Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are also responsible for the applicable Copayment/Coinsurance shown in the Benefit Summary for any ancillary Services received, such as lab tests and X-rays billed by the Qualified Provider.

If you are admitted to an Out-of-Network Hospital, you, or a relative, should call Providence Health Plan within 48 hours or as soon as reasonably possible.

When you are admitted to an Out-of-Network Hospital from an urgent care facility, your Inpatient Services are covered under your In-Network benefit until your condition becomes stable. Once your condition is stabilized, Providence Health Plan will work with you to arrange transfer to an In-Network facility. This process is called "repatriation."

Costs for non-emergency medical transport to facilitate repatriation to an In-Network facility are covered in full.

If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will be subject to your Out-of-Network benefits.

Not all Out-of-Network facilities will file a claim on a Member's behalf. If you receive urgent care Services from an Out-of-Network facility, you must submit a claim if the facility or provider does not submit it for you. See section 6.1.1.

4.6 INPATIENT HOSPITAL AND SKILLED NURSING FACILITY SERVICES

Coverage is provided, as shown in your Benefit Summary for Hospital and Skilled Nursing Facility Services. Providence Health Plan must be notified as soon as reasonably possible following the onset of treatment for coverage to continue.

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

- Room and board and supervisory or custodial Services.
- Personal hygiene and other forms of self-care.

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

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

4.6.1 Inpatient Hospital Services

Benefits are provided, as shown in your Benefit Summary.

In-Network Benefit: When your In-Network Provider and Providence Health Plan determine you need hospitalization, arrangements will be made for you to be admitted to an In-Network Hospital.

Out-of-Network Benefit: You are responsible for making sure inpatient hospitalization services are Prior Authorized by us before receiving this care from an Out-of-Network Hospital.

Only Medically Necessary Hospital Services are covered. Covered inpatient Services received in a Hospital are:

- Acute (inpatient) care;
- A semi-private room (unless a private room is Medically Necessary);
- Coronary care and intensive care;
- Isolation care; and
- Hospital Services and supplies necessary for treatment and furnished by the Hospital, such as use of the operating and recovery rooms, anesthesia, dressings, medications, whole blood and blood products, oxygen, X-ray, and laboratory Services during the period of inpatient hospitalization. (Personal items such as guest meals, slippers, etc., are not covered.)

Providence Health Plan employs professional clinical staff who may review services you receive in the Hospital. They may review your care to determine Medical Necessity, to make sure that you had quality care, and to ensure that you will have proper follow-up care.

Your provider will determine your medically appropriate length of stay. If you choose to stay in the Hospital longer than your physician advises, you will be responsible for the cost of additional days in the Hospital.

4.6.2 Skilled Nursing Facility

Benefits are provided, as shown in the Benefit Summary for Covered Services from a Skilled Nursing Facility. Services must be prescribed by your Qualified Practitioner in order to limit hospital Confinement by providing convalescent skilled medical and nursing Services which cannot be adequately provided through a home health program. Benefits are subject to the durational limits stated in your Benefit Summary.

4.6.3 Inpatient Rehabilitative Care

Benefits are provided for physical, occupational and speech therapy Covered Services, as shown in the Benefit Summary for inpatient rehabilitative care to restore or improve lost function following illness or injury. If a Member is hospitalized when rehabilitative Services begin, rehabilitative benefits will begin on the day treatment becomes primarily rehabilitative. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition. Benefits are subject to the durational limits stated in the Benefit Summary. Limits do not apply to Mental Health Covered Services. See section 4.7.2 for coverage of Outpatient Rehabilitative Services.

4.6.4 Inpatient Habilitative Care

Coverage is provided, as shown in the Benefit Summary, for Medically Necessary inpatient habilitative care. If a Member is hospitalized when habilitative Services begin, habilitative benefits will begin on the day treatment becomes primarily habilitative. All Services must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. Coverage is provided at the same benefit level as Inpatient Rehabilitative Care listed in your Benefit Summary. Limits do not apply to Mental Health Covered Services. See section 4.7.3 for coverage of Outpatient Habilitative Services.

4.6.5 Observation Care

Benefits are provided, as shown in the Benefit Summary, for Covered Services provided by the Hospital or the Qualified Practitioner while you are held in the Hospital for observation. Observation care includes the use of a bed and periodic monitoring which are reasonable and necessary to evaluate your condition as an outpatient or determine the need for possible admission to the Hospital as an inpatient. In general, the duration of observation care does not exceed 24-48 hours. Observation care for greater than 48 hours without inpatient admission is generally considered not Medically Necessary and may be subject to medical review.

4.7 OUTPATIENT SERVICES

4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Osteopathic Manipulation, Dialysis, Infusion, Chemotherapy, Radiation Therapy, and Multidisciplinary Pain Management Programs

Benefits are provided, as shown in the Benefit Summary, and include Services at a hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.6 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for invasive or non-invasive surgical procedure, outpatient cardiac rehabilitation, osteopathic manipulation and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, radiation oncology, therapeutic procedures, and approved multidisciplinary pain management programs as ordered by your Qualified Practitioner. We may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, we will not Prior Authorize the Services. For additional information about Prior Authorization, see section 3.5.

Injectable or infused medications may require a Prior Authorization. For additional information about Prior Authorization, see section 3.5. Some injectable medication may be required to be supplied by a contracted Specialty Pharmacy. Infused medications may need to be administered at a designated location or a preferred site of care (refer to Infusion Therapy Site of Care Policy and Drug List, which can be found at ProvidenceHealthPlan.com/pharmacy) or may need to be self-administered. A list of drugs, the Self-Administered Drug List, is available at ProvidenceHealthPlan.com/pharmacy. After a transition period, the member will need to self-administer at home and the prescription drug benefit applies. For more information, see section 4.14. Member may use home infusion for most therapies. Home Infusion services are available and are usually necessary for total parenteral nutrition (TPN).

Covered Services under these benefits do not include Services for Outpatient Rehabilitative Services. See section 4.7.2 for those Services.

4.7.2 Outpatient Rehabilitative Services

Benefits are included for outpatient physical, occupational and speech therapy, subject to the following limitations:

- Services must be Medically Necessary;
- Services must be provided by a physician or licensed/registered therapist, as stated in the Benefit Summary, to restore or improve lost function following illness or injury.
- Prior Authorization must be received by Providence; and
- Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition and are subject to the visit benefit maximum stated in the Benefit Summary. Limits do not apply to Mental Health Covered Services. A visit is considered a treatment with one provider (e.g., if you see a physical therapist and a speech therapist the same day at the same facility, it counts as two visits, as you have received treatment from two providers).

Providers make notifications for outpatient rehabilitation services through an authorizing agent. A notification is the initial request submitted to the authorizing agent to inform Providence Health Plan that you are starting physical therapy and/or occupational therapy services. The authorizing agent determines if the requests are approved or require medical

necessity review. For more information, visit our website at ProvidenceHealthPlan.com/OutpatientRehab.

Exclusions to outpatient Services:

- Chiropractic adjustments and manipulations of any spinal or bodily area;
- Exercise programs;
- Rolfing, polarity therapy and similar therapies; and
- Rehabilitation services provided under an authorized home health care plan, as stated in section 4.11.

See section 4.6.3 for coverage of Inpatient Rehabilitative Services.

4.7.3 Outpatient Habilitative Services

Coverage is provided, as shown in the Benefit Summary, for Medically Necessary outpatient habilitative Services. All Services are subject to review for Medical Necessity and must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. Coverage is provided at the same benefit level as Outpatient Rehabilitative Services listed in your Benefit Summary. Limits do not apply to Mental Health Covered Services. See section 4.6.4 for coverage of Inpatient Habilitative Care.

4.8 MATERNITY SERVICES

Your benefits include coverage for comprehensive maternity care.

Your Benefit Summary lists your Member costs (Deductible, Copayment and/or Coinsurance) per pregnancy for prenatal office visits, postnatal office visits and delivery Provider Services. These Member costs do not apply to other Covered Services, such as lab and imaging, which you may receive for your maternity care. The specific Coinsurance or Copayment for each of these services will apply instead. Please refer to your Benefit Summary for details.

Women may choose to receive Maternity Services from a Primary Care Provider or a Women's Health Care Provider. Women's Health Care Providers include physicians specializing in obstetrics, some Primary Care Providers and naturopaths (if they are licensed to provide obstetrical services), physician associates and advanced registered nurse practitioners specializing in women's health care, certified nurse midwives, and licensed direct entry midwives.

Covered Services include:

- Prenatal care;
- Delivery at an approved facility or birthing center*;
- Postnatal care, including complications of pregnancy and delivery;
- Emergency treatment for complications of pregnancy and unexpected pre-term birth;
- Newborn nursery care**; and
- Newborn nurse home visits***.

*If you are diverted to an Out-of-Network health care facility due to an ongoing state or federally declared public health emergency, delivery services will be covered under your In-Network benefits.

**Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit.

***Newborn nurse home visits are provided for newborns up to 6 months of age, including foster and newly adopted newborns, for Oregon members residing in a community where the Oregon Health Authority (OHA) Universal Newborn Nurse Home Visiting Program is operating. Newborn nurse home visits are covered without member cost-share (unless required for the Plan to maintain HSA-qualified status) under the newborn's In-Network benefits and must be received from nurses certified by OHA to provide the services.

PLEASE NOTE: Newborn nursery care, newborn nurse home visits, and any other Services provided to your newborn are covered only when the newborn child is properly enrolled under this Plan within time frames outlined in Newborn, Newly Adopted Children, and Newly Fostered Children Eligibility and Enrollment, section 8.2.4

IMPORTANT NOTE: Maternity Services for a Member who is serving as a surrogate parent are covered, except to the extent that such services are payable under the surrogate parenting contract or agreement.

The services of a lay, unlicensed direct entry, certified professional or any other unlicensed midwife are not covered.

Water births, regardless of location, will only be covered when performed by a licensed In-Network Provider. No coverage will be provided for water births performed by Out-of-Network Providers.

Length of maternity hospital stay: Your Services include a hospital stay of a minimum of 48 hours for a normal vaginal delivery, and a minimum of 96 hours for a Caesarean delivery. You will not be discharged from the Hospital sooner than these guidelines, unless you choose to be. You and your physician/provider will determine the length of your hospital stay and follow-up care based on accepted medical practice.

Maternity support Services: Members may attend a class to prepare for childbirth. The classes are held at In-Network Hospitals. Call the Providence Resource Line at 503-574-6595 or visit providence.org/classes for information on classes, specific dates, locations, registration and prices. Classes vary by geographic area. In addition, you can partner with Providence Health Plan Care Management from preconception to pregnancy. Licensed clinical caregivers provide support with high-risk pregnancies, fertility health services, postpartum and more. To learn more, call Care Management at 503-574-7247 or 800-662-1121 (TTY: 711) Monday through Friday, 8 a.m. to 5 p.m. (PST) or email Care.Management@Providence.org.

Diabetes coverage during pregnancy: During pregnancy through six weeks postpartum, the Plan provides coverage in full for diabetes Services, medications, and supplies when received In-Network.

4.9 MEDICAL SUPPLIES, MEDICAL APPLIANCES, PROSTHETIC AND ORTHOTIC DEVICES AND DURABLE MEDICAL EQUIPMENT (DME)

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

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

4.9.1 Medical Supplies (including Diabetes Supplies)

Benefits are shown in the Benefit Summary for the following medical supplies and diabetes supplies:

1. Medically Necessary supplies as ordered by your Qualified Practitioner, including, but not limited to, ostomy supplies, prescribed needles, syringes and chem strips. Non-sterile examination gloves used by you or your caregiver are NOT a covered medical supply.
2. Diabetes supplies, such as needles, syringes, continuous glucose monitors and blood glucose monitors, lancets and test strips, may be purchased through Providence Health Plan participating medical supply providers under your DME benefit. See section 4.14.1 for coverage of select diabetes supplies and formulary insulin pumps under your prescription benefit. Formulary, Prior Authorization, and quantity limits may apply – please see your Formulary for details. See section 4.9.4 for coverage of diabetic equipment such as insulin pump devices.
3. 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 and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition. Medical foods are also covered for the treatment of Inborn Errors of Metabolism, as described in section 4.12.2. Medical foods do not include total parenteral nutrition (TPN), which is covered under section 4.7.1.

4.9.2 Medical Appliances

Benefits are provided, as shown in the Benefit Summary for the following medical appliances:

1. Casts, braces and supportive devices when used in the treatment of medical or surgical conditions in acute or convalescent stages or as immediate post-surgical care.
2. Initial and replacement contact lenses, intraocular lenses, prescription lenses or standard frame glasses, when required as a result of injury, illness or surgery, such as, but not limited to, cataract, corneal transplant surgery or for the treatment of keratoconus.
3. Rental of an oxygen unit used in the home for Members with significant hypoxemia who are unresponsive to other forms of treatment. The benefit is limited to three

months from the initial date of Service unless there is clinical evidence of the need to continue.

4. Removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes.
5. Medical devices that are surgically implanted into the body to replace or aid function (including bilateral Cochlear Implants). If you receive a procedure to implant a medical device, you will be responsible for any Copayment or Coinsurance for the medical device in addition to any Copayment or Coinsurance for the procedure.
6. Other Medically Necessary appliances, including hearing aids and hearing assistance technology (HAT), as ordered by your Qualified Practitioner.

4.9.3 Prosthetic and Orthotic Devices

Benefits are provided for prosthetic and orthotic devices, as shown in the Benefit Summary. Coverage is limited to those prosthetic and orthotic devices that are Medically Necessary and included in the Medicare fee schedule for Durable Medical Equipment, Prosthetics, Orthotics and Supplies. Covered Services include rigid or semi-rigid devices used for supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck or an artificial limb device or appliance designed to replace in whole or in part an arm or a leg; breast implants following mastectomy; artificial eyes; and maxillofacial prosthetic devices for the restoration and management of head and facial structures. For coverage of removable custom shoe orthotics, see section 4.9.2.

4.9.4 Durable Medical Equipment (DME)

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

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

4.10 MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

This Plan complies with Oregon and Federal Mental Health Parity.

4.10.1 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 4.6.1, residential, day, intensive outpatient or partial hospitalization Services. For inpatient, residential, day, intensive outpatient, or partial hospitalization treatment services; Providence Health Plan must be notified as soon as reasonably possible following the onset of treatment for coverage to continue.

In an emergency situation, go directly to a hospital emergency room. You do not need Prior Authorization for emergency treatment; however, we must be notified within 48 hours

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

4.10.2 Applied Behavior Analysis

Benefits are provided for Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorders, subject to the following limitations:

- Services must be Medically Necessary;
- The initial screening and an individualized treatment plan must be provided by a licensed neurologist, pediatric neurologist, developmental pediatrician, psychiatrist or psychologist, who has experience or training the diagnosis of autism spectrum disorder;
- Prior Authorization is received by us;
- Benefits include coverage of any other non-excluded Mental Health or medical services identified in the individualize treatment plan;
- Treatment must be provided by a health care professional licensed to provide ABA Services; and
- Treatment may be provided in the Member's home or in a licensed health care facility.

An approved ABA treatment plan is subject to review by us and may be modified or discontinued if review shows that the Member receiving treatment is not making measurable clinical progress toward the goals identified in the treatment plan.

Exclusions to ABA Services:

- Services provided by a family or household member;
- Services that are custodial in nature, or that constitute marital, family, or training services;
- Services that are educational or correctional that are provided by a school or halfway house or received as part of an educational or training program;
- Custodial or respite care, creative arts therapy, wilderness or adventure camps, social counseling, music therapy, chelation or hyperbaric chambers;
- Services provided under an individual education plan in accordance with the Individuals with Disabilities Education Act;
- Services provided through community or social programs; and
- Services provided by the Department of Human Services or the Oregon Health Authority, other than employee benefit plans offered by the department and the authority.

4.10.3 Substance Use Disorder Services

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

Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization, as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by us.

For inpatient, residential, day, intensive outpatient, or partial hospitalization treatment services; Providence Health Plan must be notified as soon as reasonably possible following the onset of treatment for coverage to continue.

Common formulations of medications for medication-assisted treatment such as buprenorphine and naltrexone are a covered benefit when Medically Necessary. Benefits are provided as shown in the Benefit Summary. 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.

Prior Authorization is not required for medications used to treat Substance Use Disorders, including opiate addiction and withdrawal. Additionally, if your Substance Use Disorder medication has been lost, stolen, or destroyed, you are entitled to up to three early refills of your medication. If you need a refill of your Substance Use Disorder medication and your prescription has expired in the last 12 months, you are entitled to one refill of your medication without a current prescription.

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

4.11 HOME HEALTH CARE AND HOSPICE CARE

4.11.1 Home Health Care

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

Any 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 the home health care Services will be provided or coordinated by a state-licensed or Medicare-certified Home Health Agency or certified rehabilitation agency.

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

If the above criteria are not met, NO benefits will be provided under this 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; or
3. Charges for supervision of Home Health Providers.

4.11.2 Hospice Care

Benefits are included for hospice care, as shown in the Benefit Summary, and as stated in this section.

In addition, the following criteria must be met:

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

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

- Nursing care provided by or under the supervision of a registered nurse;
- 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;
- Services provided by your Qualified Practitioner or a physician associated with the hospice program;
- Durable Medical Equipment (DME), medical supplies and devices, including medications used primarily for the relief of pain and control of symptoms related to the terminal illness;
- Home health aide Services for personal care, maintenance of a safe and healthy environment and general support to the goals of the plan of care;
- Rehabilitation therapies provided for purposes of symptom control or to enable you to maintain activities of daily living and basic functional skills; and
- Continuous home care during a period of crisis in which you require skilled intervention to achieve palliation or management of acute medical symptoms.

Respite care is not covered.

4.12 OTHER COVERED SERVICES

4.12.1 Genetic Testing and Counseling Services

Genetic testing and counseling are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature.

All Direct-to-Consumer genetic tests are considered investigational and are not covered.

4.12.2 Inborn Errors of Metabolism

We will provide benefits for Covered Services, as shown in the Benefit Summary based upon the type of Services received for diagnosing, monitoring and controlling inborn errors of metabolism, including, but not limited to: phenylketonuria (PKU); homocystinuria;

citrullinemia; maple syrup disease; and pyruvate dehydrogenase deficiency; that involve amino acid, carbohydrate and fat metabolism for which medically standard methods exist, including quantification of metabolites in blood, urine, spinal fluid or enzyme or DNA confirmation in tissues. Covered Services include clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. For coverage of medical foods, see section 4.9.1.

4.12.3 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 Benefit Summary. Covered Services include, but are not limited to, the fitting and follow up exam for removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are covered, as stated in section 4.9.2 (Medical Appliances). Covered Services do not include routine foot care and the removal of corns or calluses, unless you have diabetes.

4.12.4 Reconstructive Surgery

Reconstructive Surgery is covered for conditions resulting from congenital defects, developmental abnormalities, trauma, infection, tumors or disease. Reconstructive surgery may be performed to correct a functional impairment in which the special, normal or proper action of any body part or organ is damaged; when necessary because of accidental injury or to correct scars or defects from accidental injury; or when necessary to correct scars or defects to the head or neck resulting from covered surgery. Benefits are covered as those Services listed in the Benefit Summary based upon the type of Services received. For Restoration of Head or Facial Structures; Limited Dental Services, see section 4.12.6. This exclusion does not apply to Mental Health or Substance Use Disorders.

4.12.5 Reconstructive Breast Surgery

Members who have undergone mastectomy are entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). "Mastectomy" means the surgical removal of breast tissue and breast lumps due to malignancy or suspected malignancy.

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

- All stages of reconstruction of the involved breast following a mastectomy;
- Surgery and construction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This exclusion does not apply to Mental Health or Substance Use Disorders. If you have additional questions about your WHCRA benefits, please contact Customer Service.

4.12.6 Restoration of Head/Facial Structures; Limited Dental Services

Covered Services are limited to those Services that are Medically Necessary for the purpose of controlling or eliminating infection, controlling or eliminating pain, or restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic services to improve on the normal range of conditions. Medically Necessary Covered

Services include restoration and management of head and facial structures, including teeth, dental implants and bridges, that cannot be replaced with living tissue and that are defective because of trauma, disease or birth or developmental deformities, not including overbite, crossbite, malocclusion or similar developmental irregularities of the teeth or jaw.

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

Exclusions that apply to Covered Services include:

- Cosmetic Services not considered Medically Necessary;
- Services rendered to improve a condition that falls within the normal range of such conditions;
- Routine 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 treat developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth; and
- Services to treat temporomandibular joint syndrome, including orthognathic surgery, except as provided in section 4.12.7.

Outpatient Hospitalization and Anesthesia for Limited Dental Services

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

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

Dental Services are excluded.

4.12.7 Temporomandibular Joint (TMJ) Services

Benefits are provided for TMJ Services using your In-Network benefits, as shown in the Benefit Summary. 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 5.8.2 (Medical Appliances). The benefit for the

appliance splint therapy will include an allowance for diagnostic Services, office visits and adjustments; and

6. Surgical Services.

TMJ Services are covered, as shown in your Benefit Summary; limits may apply.

Out-of-Network benefits do not apply to TMJ Services.

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

4.12.8 Self-Administered Chemotherapy

Self-administered chemotherapy agents, including oral medications and injectable medications, are covered when received from a Participating retail or specialty Pharmacy.

Self-administered chemotherapy is covered under your Outpatient Chemotherapy benefit. Self-administered chemotherapy is covered under the Prescription Drug Benefit when that coverage results in a lower out-of-pocket expense to the Member. See section 4.14.

4.12.9 Elective Sterilization

Coverage is provided, as stated below, for voluntary sterilization (tubal ligation and vasectomy).

- Tubal Ligation:
  All Covered Services must be received from Qualified Providers and Facilities.
  - In-Network: Services are covered in full.
  - Out-of-Network: Services are covered subject to the provisions of the applicable Out-of-Network benefit, e.g., your Inpatient or Outpatient Surgery benefit.
- Vasectomy:
  All Covered Services must be received from Qualified Providers and Facilities.
  - In-Network: Services are covered in full after the Deductible is met.
  - Out-of-Network: Services are covered subject to the provisions of the applicable Out-of-Network benefit, e.g., your Inpatient or Outpatient Surgery benefit.

Please note: Providence Health Plan is a Catholic-sponsored health plan, and, as a matter of conscience, Providence Health & Services facilities do not offer these Services. Services are available at other In-Network facilities.

4.12.10 Gender Dysphoria

Benefits are provided for gender affirming Services for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and select surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable Inpatient or Outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply to certain inpatient procedures. Please see section 3.5 for more information on services requiring Prior Authorization.

4.12.11 Hearing Loss Services

Definitions:

Cochlear Implant

Cochlear Implant means a device that can be surgically implanted under the skin in the bony area behind the ear (the cochlea) to stimulate hearing.

Hearing Aid

Hearing Aid means any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments, batteries, or accessory for the instrument or device, except cords.

Covered Services:

The following hearing loss services are covered under this Plan as described below. Benefits for such services are provided at the applicable benefit level for that particular type of service, as listed in your Benefit Summary.

All Covered Services must be Medically Necessary and appropriate, and prescribed, fitted, and dispensed by a licensed audiologist, hearing aid/instrument specialist, or other Qualified Practitioner.

Cochlear Implants:

Cochlear Implants for one or both ears, including fitting, programming, reprogramming, replacement and repair. Cochlear Implants require Prior Authorization. The devices are covered under the Durable Medical Equipment benefit. The implantation Services are covered under the Surgery and applicable Facility benefit.

Hearing Aids & related accessories:

Medically Necessary external hearing aids and devices, as prescribed, fitted, and dispensed by a licensed audiologist or a hearing aid/instrument specialist. Hearing aids and devices are covered under the Medical Appliances benefit. This benefit is available for one hearing aid per ear every 3 Calendar years for all Members. Hearing aid batteries are covered for one box per hearing aid per Calendar Year.

Diagnostic & Treatment Services:

Necessary diagnostic and treatment services, including office visits for hearing tests appropriate for Member's age or development need, hearing aid checks, and aided testing. Services are covered under the applicable benefit level for the service received. For example, office visits with an audiologist are covered under the Specialist office visit benefit.

Hearing Assistance Technology:

- Bone conduction sound processor headbands and prosthetic parts, if necessary for appropriate amplification of hearing loss. This benefit is available once every 3 Calendar Years for all Members.
- Hearing assistive technology systems, if necessary, for appropriate amplification of hearing loss. This benefit is available once every 3 Calendar Years for all Members.
- Necessary repair or replacement of such devices when the cost is not covered by a warranty.

Limits to Hearing Loss Services

Coverage for hearing loss services are provided in accordance with state and federal law.

4.12.12 Wigs

The Plan will provide coverage for one wig every Calendar Year for Members who have undergone chemotherapy or radiation therapy or are experiencing drug-induced Alopecia at the Medical Equipment, Supplies and Devices benefit level listed in your Benefit Summary. A wig is a full cranial hair prosthesis to use as a hair loss solution or hair replacement. Wigs may be purchased from any wig supplier. Wig suppliers may require Members to pay for items and submit the paid receipt to Providence Health Plan for reimbursement. For information about submitting claims, see section 6.1.1.

4.12.13 Biofeedback

Coverage is provided, as shown in the Benefit Summary for biofeedback to treat migraine headaches or urinary incontinence. Services must be Medically Necessary and within the Qualified Practitioner's scope of license.

4.12.14 Chiropractic Manipulation

Coverage is provided for chiropractic manipulation, as stated in your Benefit Summary. To be eligible for coverage, all chiropractic manipulation Services must be Medically Necessary and within the Qualified Practitioner's scope of license.

4.12.15 Acupuncture

Coverage is provided for acupuncture, as stated in your Benefit Summary. To be eligible for coverage, all acupuncture Services must be Medically Necessary and within the Qualified Practitioner's scope of license.

4.12.16 Fertility Preservation Services

The Plan covers Fertility Preservation for Members with sickle cell disease or where treatment related to cancer conditions may cause irreversible infertility as recommended by evidence-based guidelines such as the National Comprehensive Cancer Network (NCCN).

Covered Services include the following:

- Office visits, counseling and procedures related to Fertility Preservation;
- Retrieval and storage of eggs and sperm;
- Drugs related to retrieval and storage of eggs and sperm for Fertility Preservation. Examples include medications used to stimulate the ovaries for oocyte (egg) retrieval.

Infertility treatment, including in-vitro fertilization, is NOT covered as part of this benefit.

4.12.17 Orthoptics and Vision Training

Coverage is provided, as shown in the Benefit Summary for Vision Therapy to treat Convergence Insufficiency. Services must be Medically Necessary and within the Qualified Practitioner's scope of license.

4.12.18 Other Medical Services and Devices

This Plan covers support for implantable and external medical devices that are vital to your well-being. Coverage for initial device setup, device training, and evaluation of device

functionality is provided when performed by a Qualified Practitioner. This coverage is subject to your In-Network and Out-of-Network coinsurance, as shown in your Benefit Summary. Coverage includes, but is not limited to, cardiac rhythm management devices, eye tracking devices for amblyopia, and both speech and non-speech generating devices.

4.13 HUMAN ORGAN/TISSUE TRANSPLANTS

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

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

The term transplant does not include Services related to the transfusion of blood or blood derivatives (except hematopoietic stem cells) or replacement of a cornea. Corneal replacement is covered under the applicable provider and facility surgical benefits.

4.13.1 Covered Services

Covered Services for transplants are limited to Services that:

1. Are determined by us to be Medically Necessary and medically appropriate according to national standards of care;
2. Are provided at a facility approved by us or under contract with us **(the Out-of-Network benefit does NOT apply to transplant Services)**;
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 per transplant benefit maximum for transportation, food and lodging. Food and lodging is subject to a $300 per diem. Per Diem expenses apply to the $5,000 travel expenses per transplant benefit maximum. (Note: Travel expenses are not covered for donors.)

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

1. Initial evaluation of the donor and related program administration costs;
2. Preserving the organ or tissue;
3. Transporting the organ or tissue to the transplant site;

4. Acquisition charges for cadaver or live donor;
5. Services required to remove the organ or tissue from the donor; and
6. Treatment of medical complications directly resulting from the surgery performed to obtain the organ or tissue for a period of time not to exceed 30 consecutive days following that surgery.

4.13.2 Benefits for Transplant Facility Services Provided to the Organ Recipient

The Member/recipient is responsible for the Deductible, Coinsurance or Copayment amounts for pre-transplant services and post-transplant services at the applicable Inpatient Hospital Services and Outpatient Facility Services benefit.

The transplant procedure and related inpatient services are billed at a Global Fee. The Global Fee can include facility, professional, organ acquisition and inpatient day charges. It does not include pre-transplant and post-transplant services. The Member/recipient is responsible for the Deductible, Coinsurance or Copayment amounts for the Global Fee at the applicable Inpatient Hospital Service benefit.

The Global Fee and the pre-transplant and post-transplant Services will apply to the Member's Out-of-Pocket Maximum.

4.13.3 Benefits for Outpatient Medications

Outpatient prescription medications for transplant-related Services, including anti-rejection (immunosuppressive) drugs, are covered under the Prescription Drug Benefit and those benefits are subject to the terms and limitations of that Benefit. See section 4.14.

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

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

4.13.5 Transplant Prior Authorization

(See also section 3.5.)

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

4.13.6 Transplant Exclusions

In addition to the exclusions listed in section 5, the following exclusions apply to human organ/tissue transplants:

- Any transplant procedure performed at a transplant facility that has not been approved by us;
- Any transplant that is Investigational, as determined by us;
- Services or supplies for any transplant that are not specified as Covered Services in section 4.13, such as transplantation of animal organs or artificial organs;
- Services related to organ/tissue donation by a Member if the recipient is not a Member or the Member/recipient is not eligible for transplant benefits under this Plan; and
- Transplant-related travel expenses for the donor and the donor's and recipient's Family Members.

4.14 PRESCRIPTION DRUG BENEFIT

The Prescription Drug Benefit provides coverage for self-administered prescription drugs which are Medically Necessary for the treatment of a covered illness or injury and which are dispensed by a Participating Pharmacy pursuant to a prescription ordered by a Qualified Practitioner for use on an outpatient basis, subject to your Plan's benefits, limitations and exclusions.

Self-Administered Prescription Drug Definition

Self-Administered Prescription Drugs mean medicinal substances designated by the Pharmacy & Therapeutics Committee for self-administration and dispensed from a Participating Retail. Mail Order or Specialty Pharmacy and labeled for self-administration.

The following are considered "Prescription Drugs;"

1. Any medicinal substance which bears the legend, "RX ONLY" or "Caution: federal law prohibits dispensing without a prescription;"
2. Any medicinal substance of which at least one ingredient is a federal legend drug in a therapeutic amount;
3. Any medicinal substance that the Food and Drug Administration (FDA) reviews for safety and benefit. Products labeled "Not evaluated by the FDA" are excluded;
4. Any compounded drug product prepared using pharmaceutical grade active ingredients, which are reviewed by the FDA for safety and benefit;
5. Insulin; and
6. Any medicinal substance which has been approved by Oregon's Health Evidence Review Commission (HERC) as effective for the treatment of a particular indication.

Prescription Drugs, including oral, topical and injectable medications delivered, injected or administered to you by a physician, other provider, or trained person in a Provider's office or other facility are not covered under your Prescription Drug Benefit. Prescription drugs administered in a Provider's office or other facility are subject to the applicable benefit. For example, Prescription Drugs delivered in a Provider's Office may be subject to your Allergy Shots and Allergy Serums benefit (see section 4.3.5). For details about Injectable and Infused Medications, refer to sections 4.3.6, 4.7.1, and 4.14.1

Select self-administered injectable medications are medications which have been identified as being medically appropriate for administration by a patient or their caregiver, safely and effectively, without medical supervision. Certain medications considered to be usually self-administered by the patient or their caregiver are excluded from coverage under the medical benefit without Prior Authorization. A transition period may be allowed for a member to receive the drug at the Provider's office, clinic, or facility. A list of these drugs, the Self-Administered Drug List, can be found on the Providence Pharmacy Resources website at ProvidenceHealthPlan.com/pharmacy. After this transition period, the member will need to self-administer at home and Your Prescription Drug Benefit applies.

4.14.1 Using Your Prescription Drug Benefit

Your prescription drug benefit requires that you fill your prescriptions at a Participating Pharmacy.

You have access to Providence Health Plan's nationwide broad pharmacy network as published in our pharmacy directory.

Providence Health Plan Participating Pharmacies are those pharmacies that maintain all applicable certifications and licenses necessary under state and federal law of the United States and have a contractual agreement with us to provide Prescription Drug Benefits.

Participating Pharmacies are designated as retail, preferred retail, specialty and mail-order Pharmacies. To view a list of Participating Pharmacies, visit our website at ProvidenceHealthPlan.com/pharmacy. You also may contact Customer Service at the telephone number listed on your Member ID card.

- Please present your Member ID Card to the Participating Pharmacy at the time you request Services. If you have misplaced or do not have your Member ID Card with you, please ask your pharmacist to call us.
- All Covered Services are subject to the Deductible, Copayments and/or Coinsurance listed in your Benefit Summary. Benefit maximums may also apply as defined in the handbook.
- Participating Pharmacies may not charge you more than your Copayment or Coinsurance, except when Deductible and/or coverage limitations apply. Please contact Customer Service if you are asked to pay more or if you, or the pharmacy, have questions about your Prescription Drug Benefit or need assistance processing your prescription.
- Copayments or Coinsurance are due at the time of purchase. If the cost of your Prescription Drug is less than your Copayment, you will only be charged the cost of the Prescription Drug.
- You may be assessed multiple Copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- You may purchase up to a 90-day supply of each maintenance drug at one time using a Participating mail service or preferred retail Pharmacy. Not all drugs are covered for more than a 30-day supply, including compounded medications, drugs obtained from specialty pharmacies, and limited distribution pharmaceuticals. To obtain prescriptions by mail, your physician or provider can call in or electronically send the prescription, or you can mail your prescription along with your Providence Health Plan Member ID number to one of our Participating mail-order Pharmacies. To find our

Participating mail-order Pharmacies, please visit our website at ProvidenceHealthPlan.com/pharmacy. (Not all prescription drugs are available through our mail-order pharmacies).

- Providence Health Plan will provide Members prescription synchronization services for maintenance medications. Upon Member or provider request, the Plan will coordinate with Members, providers, and the dispensing pharmacy to synchronize maintenance medication refills so Members can pick up maintenance medications on the same date. Members will be responsible for applicable Copayments, Coinsurances and Deductibles.
- Diabetes supplies and inhalation extender devices may be obtained at your Participating Pharmacy. Refer to your formulary for a list of diabetes supplies that may be covered under your prescription benefit when obtained at a pharmacy. All other continuous glucose monitors, insulin pumps, and all diabetic supplies obtained at a DME provider are considered medical supplies and devices. See section 4.9.1 and your Benefit Summary.
- Insulin pump devices, except those listed on your formulary, are covered under your Durable Medical Equipment benefit (section 4.9.4).
- Select self-administered injectable medications are not covered when supplied in a provider's office, clinic or facility. Medications listed on the Self-Administered Drug list may be administered by a healthcare provider in a provider's office, clinic, or facility for a transition period, and benefits in section 4.3.6 apply. Please refer to the Providence Pharmacy Resource website at ProvidenceHealthPlan.com/pharmacy for the Self-Administered Drug list. After this transition period, you will need to self-administer at home and your prescription drug benefit applies.
- Injectable medications received in your Provider's office are covered under section 4.3.6.
- Infusions, including infused medications, received at Outpatient Facilities are covered under section 4.7.1.
- Some prescription drugs require Prior Authorization or an exception to the formulary in order to be covered; these may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in our Prescription Drug Formulary available on our website at ProvidenceHealthPlan.com/pharmacy or by contacting Customer Service.

4.14.2 Use of Out-of-Network Pharmacies

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

To request reimbursement, you will need to fill out and submit to Providence Health Plan a Prescription Drug Reimbursement form. This form is available on our website or by contacting Customer Service. When you submit the completed Prescription Drug Reimbursement form, include any itemized pharmacy receipts along with an explanation as to why you used an Out-of-Network Pharmacy. Submission of a claim does not guarantee payment.

If your claim is approved, we will reimburse you the cost of your prescription up to our Participating Pharmacy contracted rates, less your Deductible, Copayment or Coinsurance if applicable. Reimbursement is subject to your Plan's limitations and exclusions. You are responsible for any amounts above our contracted rates.

International prescription drug claims will only be covered when prescribed for emergent conditions and will be subject to your medical Emergency Services benefit and any applicable Plan limitations and exclusions.

4.14.3 Prescription Drug Formulary

The Formulary is a list of Food and Drug Administration (FDA)-approved prescription drugs. It is designed to offer drug treatment choices for covered medical conditions. Formulary status is given to drugs which meet evidence-based assessment of therapeutic effectiveness, safety, pharmacoeconomic value and offer an important advantage to existing Formulary alternatives.

The Formulary can help you and your Qualified Practitioner choose effective medications that are less costly and minimize your out-of-pocket expenses. There are effective generic drug choices that treat most medical conditions.

Not all FDA-approved drugs are covered by Providence Health Plan. Non-formulary drug requests require a formulary exception, must be FDA-approved, Medically Necessary, and require by law a prescription to dispense. See section 6.1 under Claims Involving Prior Authorization and Formulary Exception.

Newly approved FDA drugs will be reviewed by the Oregon Region Pharmacy and Therapeutics Committee for safety and Medical Necessity within 12 months after the drug becomes available on the market. In the case of an urgent situation, you may request coverage of a newly approved FDA drug through the Prior Authorization process during our review period.

To access the formulary for your plan, visit ProvidenceHealthPlan.com/pharmacy.

4.14.4 Prescription Drugs

Generic and Brand-Name Prescription Drugs

Both generic and brand-name drugs are covered benefits subject to the terms of your Benefit Summary. In general, generic drugs are subject to lower Copayments or Coinsurances than brand-name drugs. Please refer to your Benefit Summary for your Copayment or Coinsurance information.

If you request a brand-name drug, or if your provider prescribes a brand-name drug when a generic is available, regardless of the reason or Medical Necessity, you will be responsible for the difference in cost between the brand-name and generic drug, in addition to the brand-name drug Copayment or Coinsurance indicated on the Benefit Summary. Your total cost, however, will never exceed the actual cost of the drug. The difference in cost between the brand-name and generic drug will not be applied toward your Out-of-Pocket Maximum, and you will continue to be responsible for the difference in cost after your Out-of-Pocket Maximum is met.

If a generic equivalent exists or becomes available, or if the cost of a brand-name drug changes, the tier placement of the brand-name drug may change or require a formulary exception (which is a form of Prior Authorization). The brand-name drug may also no longer be covered. If your brand-name drug is authorized through formulary exception and our formulary includes a generic equivalent, you will be responsible for the difference in cost

between the brand-name and the generic drug and the difference in cost will apply toward your Calendar Year Deductible and Out-of-Pocket Maximum.

Affordable Care Act Preventive Drugs

In accordance with the Affordable Care Act (ACA) your plan covers, at no cost to you, certain preventive medications, including contraceptives, both prescription and Over-the-counter, when these medications are purchased from Participating Pharmacies. ACA preventive drugs that your Plan covers are listed on your Formulary. Over-the-counter ACA preventive drugs received from Participating Pharmacies will not be covered in full under the ACA preventive benefit without a written prescription from your Qualified Practitioner. Over-the-counter contraceptives do not require a written prescription, as required by ORS 743A.067(2(j)(C) or 743A.067(4).

Core Preventive Drugs

The Core Preventive drug list is made up of medications that Providence Health Plan has selected, with the guidance of our Clinical Pharmacy Division. These are first-line medications that may prevent the onset of a disease or condition when taken by a person who has developed risk factors for the disease or condition that has not yet manifested itself or has not become clinically apparent, or may prevent the recurrence of a disease or condition from which a person has recovered.

Core Preventive drugs are subject to formulary and tier status, as well as pharmacy management programs such as Prior Authorization, step therapy, and/or quantity limits. Providence Health Plan has developed the list of Core Preventive drugs based on IRS Notices 2019-45 and 2004-23, section 223(c)(2)(C) of the Internal Revenue Code.

4.14.5 Prescription Drug Quantity

Prescription dispensing limits, including refills, are as follows:

1. Topicals, up to 60 grams;
2. Liquids, up to eight ounces;
3. Tablets or capsules, up to 100 dosage units;
4. Multi-use or unit-of-use, up to one container or package; as prescribed, not to exceed a 30-consecutive-day supply, whichever is less;
5. FDA approved women's prescription contraceptives: up to 3-months initial dispensing, then up to 12-months subsequent dispensing at any Participating Pharmacy; and
6. Opioids up to 7 days initial dispensing, except for buprenorphine and brand equivalent products indicated for the treatment of opioid use disorder.

Other dispensing limits may apply to certain medications requiring limited use, as determined by our Oregon Region Pharmacy and Therapeutics Committee. Prior Authorization is required for amounts exceeding any applicable medication dispensing limits.

4.14.6 Participating Mail-Order and Preferred Retail Pharmacies

Up to a 90-day supply of prescribed maintenance drugs (drugs you have been on for at least 30 days and that you anticipate continuing on in the future) purchased from a Participating

mail-order or preferred retail Pharmacy will be covered subject to the following specific provisions:

1. Qualified drugs under this program will be determined by Providence Health Plan. Not all prescription drugs are available through mail-order pharmacy.
2. Not all maintenance prescription drugs are available in 90-day allotments.
3. Copayment(s) will be applied to the quantity stated on your Benefit Summary. (Some quantity limitations and Copayments for unit of use packaging may apply).

When using a mail-order pharmacy, payment is required prior to processing your order. If Providence Health Plan removes a pharmacy from its network, we will notify you of this change at least 30 days in advance. Notification may be done via the online directory or letter depending on the circumstance.

4.14.7 Prescription Drug Limitations

Prescription drug limitations are as follows:

1. All drugs must be Food and Drug Administration (FDA) approved, Medically Necessary and require by law a prescription to dispense. Not all FDA-approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety and Medical Necessity within 12 months after the drug becomes available on the market for Formulary consideration.
2. Certain drugs require Prior Authorization for Medical Necessity, place of therapy, length of therapy, step therapy, number of doses or dispensing limits. Step therapy uses our pharmacy claims history to confirm if certain drugs have been tried first by a Member. If a drug has not been tried first, cannot be tried first, or if the drug history is not available, Prior Authorization is required. For some drugs, we limit the amount of the drug we will cover. You or your Qualified Practitioner can contact us directly to request Prior Authorization. If you have questions regarding a specific drug, please call Customer Service.
3. Specialty drugs are injectable, infused, oral, topical, or inhaled therapies that often require specialized delivery, handling, monitoring and administration and are generally high cost. These drugs must be purchased through our designated specialty pharmacy. Due to the nature of these medications, specialty drugs are limited to a 30-day supply. Specialty drugs are listed in our Formulary. In rare circumstances specialty medications may be filled for greater than a 30-day supply; in these cases, additional specialty cost share(s) may apply.
4. Self-injectable medications are only covered when they are being self-administered and labeled by the FDA for self-administration; in some cases, a Prior Authorization may be required for the drug. Documentation of self-administration may also be required. Drugs labeled for self-administration that are being administered by a provider will fall to the Member's medical benefit.
5. Compounded prescriptions are subject to clinical review for Medical Necessity and Plan and benefit limitations. They are not guaranteed for payment. Compound drugs prepared using pharmaceutical-grade active ingredients may be approved. The product must be prescribed in a therapeutic amount, must meet our Medical Necessity criteria, and must be purchased at a Participating Pharmacy. Products with the disclaimer that the drug/product has not been reviewed by the FDA will not be covered. Inactive ingredients (e.g., fillers) used in the compound of the product that have been deemed not safe and/or beneficial by the FDA will not be covered.
6. In accordance with the Affordable Care Act (ACA), your Plan covers, at no cost to you, certain preventive medications, including contraceptives, both prescription and Over-

the-counter, when these medications are purchased from Participating Pharmacies. Not all preventive medications are required to be covered in full though. The ACA allows Plans to use reasonable medical management to select medications that are covered in full (for example, when there is a generic medication available, the brand name may not be covered in full). If your Provider does not feel that the medications covered in full by your Plan are the right ones for you, you may request coverage for a similar medication at $0 Cost-Share by submitting a Prior Authorization.

7. Vacation supply overrides are limited to a 30-day supply.
8. A 30-day supply override may be granted if you are out of medication and have not yet received your drugs from a Participating mail-order Pharmacy.

4.14.8 Prescription Drug Exclusions

In addition to the Exclusions listed in section 5, Prescription Drug Exclusions are as follows:

1. Drugs or medicines delivered, injected or administered to you by a physician or other provider or another trained person (see section 4.3.5);
2. Drugs prescribed that do not relate to the prevention or treatment of a covered illness or injury;
3. Drugs used for the treatment of fertility/infertility, except when used in the treatment of Fertility Preservation for oncological conditions and sickle cell disease as outlined in section 4.12.16;
4. Fluoride, for Members over 16 years of age;
5. Drugs that are not provided in accordance with our Formulary management program or are not provided according to our medical policy;
6. Drugs used in the treatment of fungal nail conditions;
7. Over-the-counter (OTC) drugs or vitamins, that may be purchased without a provider's written prescription, except as required by federal or Oregon state law;
8. Prescription drugs, including prescription combination drugs, that contain OTC products or are available in an OTC therapeutically similar form;
9. Drugs dispensed from pharmacies outside the United States, except when prescribed for Urgent Care and Emergency Medical Conditions or as required by federal or Oregon state law;
10. Drugs, which may include prescription combination drugs, placed on a prescription-only status as required by state or local law;
11. Replacement of lost, stolen or damaged medication;
12. Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy's standard packaging for the place of service submitted;
13. Drugs or medicines used to treat sexual dysfunction (this exclusion does not apply to Mental Health Covered Services);
14. Drugs dispensed or compounded by a pharmacist that do not have at least one FDA-approved medication in therapeutic amount;
15. Drugs used for cosmetic purposes;
16. Drugs used for weight loss;
17. Drugs used to treat hair loss;
18. Drug kits, unless the product is available solely as a kit. Kits typically contain a pre-packaged drug along with items associated with the administration of the drug (e.g., gloves, shampoo);
19. Drugs that are not FDA-approved or are designated as "less than effective" by the FDA (also known as "DESI" drugs);
20. Vaccines and medications solely for the purpose of preventing travel related diseases, as defined by the CDC;

21. Early refill, except when there is a change in directions or if synchronizing your prescription refills. This exclusion does not apply to eye drops prescribed for the treatment of glaucoma; and
22. For drugs obtained at in-network pharmacies without using your pharmacy benefit, reimbursement is limited to our in-network contracted rates, except in the case of Urgent/Emergent situations. This means you may not be reimbursed the full cash price you pay to the pharmacy. Drugs obtained from out-of-network pharmacies are not eligible for reimbursement, except in the case of Urgent/Emergent situations.

4.14.9 Prescription Drug Disclaimer

Providence Health Plan is 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.

4.14.10 Specialty Pharmacy Variable Copay Program

Many specialty medications have manufacturer programs that may provide financial assistance for the purchase of the medication. We may help you determine whether your specialty medication is eligible for financial assistance, and if eligible, your Copayment and/or Coinsurance may vary. For medications not subject to this program, and if you choose not to participate in the program, regular plan benefits will apply. Due to federal regulation, Health Savings Account (HSA) plans are not eligible for this program. After you have reached your annual Out-of-Pocket Maximum, the Program will continue to apply any available manufacturer-funded patient assistance, but you will not have any actual out-of-pocket payments for the rest of the Plan Year. If the Program is unable to secure financial assistance, regular plan benefits will apply.

4.15 GENE AND ADOPTIVE CELLULAR THERAPY

Gene and Adoptive Cellular Therapies are techniques that replace or modify a person's genes or cells to treat or cure some cancers and genetic diseases. Coverage is provided for Gene and/or Adoptive Cellular Therapy for Medically Necessary infusion benefits. Services are subject to Prior Authorization.

Coverage is also provided for travel expenses for Gene and Adoptive Cellular Therapy. These travel expenses are subject to a $7,500 per calendar year maximum for transportation, food, and lodging. Deductible applies before reimbursement on HSA plans. Food and lodging is subject to a $300 per diem. Per Diem expenses apply to the $7,500 per calendar year benefit maximum.

5. EXCLUSIONS

In addition to those Services listed as not covered in section 4, the following are specifically excluded from coverage under this Plan.

IMPORTANT NOTE: Your Employer may have purchased a Supplemental Benefit offering some of the services excluded below. If this is the case, a separate Benefit Summary for each of your Supplemental Benefits will be included in your Member materials. See section 13 for more information regarding Supplemental Benefits.

General Exclusions:

We do not cover Services and supplies which:

- Are not provided;
- Are provided without charge or for which you would not be required to pay if you did not have this coverage;
- Are received before the Effective Date of Coverage;
- Are not a Covered Service or relate to complications resulting from a Non-Covered Service, except for Services provided as Emergency Care, as described in section 4.5;
- Are not furnished by a Qualified Practitioner or Qualified Treatment Facility;
- Are provided by or payable under any health plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law;
- Are provided while you are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies, except to the extent provided by 38 U. S. C. § 1729 as it relates to non-military Services provided at a Veterans Administration Hospital or facility;
- Are provided while you are in the custody of any law enforcement authorities or while incarcerated, except as provided in section 3.3;
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos, books and educational programs to which drivers are referred by the judicial system and volunteer mutual support groups;
- Are provided to yield primarily educational outcomes, unless Medically Necessary or as otherwise covered under the Preventive Services benefit described in section 4.1. An outcome is “primarily educational” if the outcome’s fundamental, first, or principal character is to provide you with enduring knowledge, skill, or competence through a process of repetitive positive reinforcement over an extended length of time. An outcome is “enduring” if long-lasting or permanent;
- Are performed in association with a Service that is not covered under this Plan, except Emergency Services;
- Are provided for any injury or illness that is sustained by any 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 Member. This exclusion also applies to injuries and illnesses that are the subject of a claim settlement where medical coverage is inclusive of and provided for under the terms of the settlement, such as a claim disposition agreement, applicable under a Workers’ Compensation Act or similar law. This exclusion does not apply to Members who are exempt under any Workers’ Compensation Act or similar law;
- Are payable under any automobile medical, personal injury protection (“PIP”), automobile no-fault, homeowner, commercial premises coverage, or similar contract

or insurance, when such contract or insurance makes benefits or Services available to you, whether or not you make application for such benefits or Services and whether or not you are refused payment for failure to satisfy any term of such coverage. If such coverage is required by law and you unlawfully fail to obtain it, benefits will be deemed to have been payable to the extent of that requirement. This exclusion also applies to charges applied to the Deductible of such contract or insurance. Any benefits or Services provided under this Plan that are subject to this exclusion are provided solely to assist you and such assistance does not waive our right to reimbursement or subrogation as specified in section 6.3. This exclusion also applies to Services and supplies after you have received proceeds from a settlement as specified in section 6.3.3;

- Are provided in a facility that specializes in treatment of developmental disabilities, except as provided in section 4.10.2;
- Are provided for treatment or testing required by a third party or court of law which is not Medically Necessary;
- Are Investigational;
- Are determined by us not to be Medically Necessary for diagnosis and treatment of an injury or illness;
- Are received by a Member under the Oregon Death with Dignity Act;
- Have not been Prior Authorized as required by this Plan; and
- Relate to any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member if such Member is 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 punishable by up to a year's imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or medical condition (i.e., a physical or mental health condition). This exclusion does not apply to Mental Health or Substance Use Disorder Services;

We do not cover:

- Charges that are in excess of the Usual, Customary and Reasonable (UCR) charges;
- Custodial Care;
- Transplants, except as provided in section 4.13;
- Services for Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices and Durable Medical Equipment (DME), except as described in section 4.9;
- 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 rehabilitative services, except as provided in sections 4.6.3 and 4.7.2;

- "Telephone visits" by a physician or "environment intervention" or "consultation" by telephone for which a charge is made to the patient, except as provided in section 4.3.2;
- "Get acquainted" visits without physical assessment or diagnostic or therapeutic intervention provided and online treatment sessions;
- Missed appointments;
- Non-emergency medical transportation, except as provided in section 4.5.1;
- Allergy shots and allergy serums, except as provided in section 4.3.5;
- All Services and supplies related to the treatment of obesity or morbid obesity, except as provided in section 4.1 and 4.10.1 and when added to this Plan as a Supplemental Benefit in section 13.3;
- Services for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas, except as provided in section 4.1.7 and when added to this Plan as a Supplemental Benefit;
- Transportation or travel time, food, lodging accommodations and communication expenses, except as provided in sections 3.6 and 4.13 and with our prior approval;
- Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
- Biofeedback, except as provided in section 4.12.13;
- Thermography;
- Homeopathic procedures;
- Comprehensive digestive stool analysis, cytotoxic food allergy test, dark-field 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, and zinc tolerance test;
- Chiropractic manipulation and acupuncture, except as provided in sections 4.12.14 and 4.12.15
- Massage therapy, except when covered as a Supplemental Benefit to this Plan;
- Light therapy for seasonal affective disorder, including equipment;
- Any vitamins, dietary supplements, and other non-prescription supplements, except as required by federal or Oregon state law;
- Services for genetic testing are excluded, except as provided in section 4.12.1. Genetic testing is not covered for screening, to diagnose carrier states, or for informational purposes in the absence of disease;
- Services to modify the use of tobacco and nicotine, except as provided in section 4.1.8 or when provided as Extra Values or Discounts (see our website at ProvidenceHealthPlan.com), where available;
- Cosmetic Services including supplies and drugs not considered Medically Necessary;
- Services, including routine physical examination, immunizations and vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel;
- Non-sterile examination gloves;
- Sales taxes, handling fees and similar surcharges, as explained in the definition of UCR;

- Air ambulance transportation for non-emergency situations is not covered, except as provided in section 4.5.2;
- Services provided under a court order or as a condition of parole or probation or instead of incarceration, unless Medically Necessary;
- Personal growth services such as assertiveness training or consciousness raising;
- School counseling and support services, peer support services, tutor and mentor services, independent living services, household management training, and wraparound services that are provided by a school or halfway house and received as part of an education or training program;
- Recreation 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;
- Counseling related to family, marriage, sex and career including, but not limited to, counseling for adoption, custody, family planning or pregnancy. This exclusion does not apply to Mental Health or Substance Use Disorders;
- Neurological Services and tests including, but not limited to, EEGs, PET, CT, MRA and MRI imaging Services, and beam scans (except as provided in section 4.4.1);
- Vocational, pastoral or spiritual counseling;
- Viscosupplementation (i.e., hyaluronic acid/hyaluronan injection);
- All Direct-to-Consumer testing products; and
- Dance, poetry, music or art therapy, except as part of an approved treatment program.

Exclusions that apply to Provider Services:

- Services of homeopaths; faith healers; or lay, unlicensed direct entry, and certified professional midwives; and
- Services of any unlicensed providers.

Exclusions that apply to Reproductive Services:

- All services related to sexual disorders or dysfunctions regardless of gender or cause, except as provided in section 4.12.6. This exclusion does not apply to Mental Health Covered Services;
- All of the following services, except as described in section 4.12.16:
    - All services related to surrogate parenting, except Maternity Services, as described in section 4.8;
    - All services related to in vitro fertilization, including charges for egg/semen harvesting and storage;
    - All services related to artificial insemination, including charges for semen harvesting and storage;
    - All services and prescription drugs related to Fertility Preservation;
    - Diagnostic testing and associated office visits to determine the cause of infertility;
    - All of the following services when provided for the sole purpose of diagnosing and treating an infertile state or artificial reproduction:
        - Physical examination;
        - Related laboratory testing;

        - Instruction;
        - Medical and surgical procedures, such as hysterosalpingogram, laparoscopy, or pelvic ultrasound; and
        - Related supplies and prescriptions.

    For the purpose of this exclusion:
        - Infertility or infertile means the failure to become pregnant after a year of unprotected intercourse or the failure to carry a pregnancy to term as evidenced by three consecutive spontaneous abortions;
        - Artificial reproduction means the creation of new life other than by the natural means;
- Termination of pregnancy, unless there is a severe threat to the mother, or if the life of the fetus cannot be sustained. Providence has a religious objection to providing this service in other circumstances. However, enrollees in this Plan have coverage for termination of pregnancy services not covered under this Plan through the Oregon Health Authority's Reproductive Health Program, which administers the Abortion Access Plan. For information on how to receive these services, please contact the Oregon Reproductive Health Program at https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/ABORTIONACCESS/Pages/access-plan.aspx or rh.billing@oha.oregon.gov. You are not required to notify or interact with Providence Health Plan in any way concerning such non-covered services;
- Reversal of voluntary sterilization; and
- Services provided in a premenstrual syndrome clinic or holistic medicine clinic.

Exclusions that apply to Vision Services:

- Surgical procedures which alter the refractive character of the eye, including, but not limited to, laser eye surgery, radial keratotomy, myopic keratomileusis and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia, hyperopia or astigmatism;
- Services for routine eye care and vision care, vision exams/screenings, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in sections 4.1.1, 4.1.5, 4.5.3 and 4.9.2 and, if applicable, as covered under the Vision Supplemental Benefit; and
- Vision training except as provided in section 4.12.17.

Exclusions that apply to Hearing Services:

- Hearing aids, hearing therapies and/or devices, including all services related to the examination and fitting of the Hearing Aids, except as provided in section 4.12.11.

Exclusions that apply to Dental Services:

- Oral surgery (non-dental or dental) or other dental services (all procedures involving the teeth, wisdom teeth, areas surrounding the teeth, and dental implants), except as approved by us and described in section 4.12.6;
- Services for orthognathic surgery, except as approved by us and described in section 4.12.6;
- Services to treat temporomandibular joint syndrome (TMJ), except as provided in section 4.12.7; and
- Dentures and orthodontia, except as provided in sections 4.12.6.

Exclusions that apply to Foot Care Services:

- Routine foot care, such as removal of corns and calluses, except for Members with diabetes; and
- Services for orthotics, insoles, arch supports, heel wedges, lifts and orthopedic shoes, except as described in section 4.9.3.

Exclusions that apply to Prescription Drugs, Medicines and Devices:

- Outpatient prescription drugs, medicines and devices, except as provided in sections 4.2.4, 4.12.8 and 4.14; and
- 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.

6. CLAIMS ADMINISTRATION

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

6.1 CLAIMS PAYMENT

Our 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 us will be made only upon your written notice to us of the payment. Payment will be made to the Subscriber, subject to written notice of claim, or, if deceased, to the Subscriber's estate, unless payment to other parties is authorized in writing by you.

Explanation of Benefits (EOB)

You will receive an EOB from Providence Health Plan after we have processed your claim. An EOB is not a bill. An EOB explains how Providence Health Plan processed your claim, and will assist you in paying the appropriate Member responsibility to your provider. Copayment or Coinsurance amounts, Deductible amounts, Services or amounts not covered and general information about our processing of your claim are explained on an EOB.

Time Frames for Processing Claims

If Providence Health Plan denies your claim, we will send an EOB to you with an explanation of the denial within 30 days after we receive your claim. If we need additional time to process your claim for reasons beyond our control, we will send a notice of delay to you explaining those reasons within 30 days after we receive your claim. We will then complete our processing and send an EOB to you within 45 days after we receive your claim. If we need additional information from you to complete our processing of your claim, we will send you a separate request for information and you will have 45 days to submit the additional information. Once we receive the additional information from you we will complete our processing of the claim within 30 days.

Claims Involving Prior Authorization and Formulary Exception (Pre-Service Claims)

- For Prior Authorization of services that do not involve urgent medical conditions: Providence Health Plan will notify your provider or you of its decision within two business days after the Prior Authorization request is received. If additional information is needed to process the request, Providence Health Plan will provide written notice to the Member and the provider within two business days of receiving the Prior Authorization request. The Member and the provider will have 15 days to submit the additional information. Within two business days of receipt of the additional information, Providence Health Plan will complete its review and provide written notice of its decision to the Member and the provider. If the additional information is not received within 15 days, the request will be denied.
- For Prior Authorization of services that involve urgent medical conditions: Providence Health Plan will notify your provider or you of its decision within 72 hours after the Prior Authorization request is received. If Providence Health Plan needs additional information to complete its review, it will notify the requesting provider or you within 24 hours after the request is received. The requesting provider or you will then have 48 hours to submit the additional information. Providence Health Plan will complete

its review and notify the requesting provider or you of its decision by the earlier of (a) 48 hours after the additional information is received or, (b) if no additional information is provided, 48 hours after the additional information was due.

- **For formulary exceptions:** For standard requests, Providence Health Plan will notify your provider or you of its decision within 72 hours after receipt of the request. For expedited requests, Providence Health Plan will notify your provider or you of its decision within 24 hours after receipt of the request. To qualify for expedited review, the request must be based upon exigent circumstances.

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. Providence Health Plan will then notify you of its reconsideration decision within 24 hours after your request is received.

6.1.1 Timely Submission of Claims

We will make no payments for claims received more than 365 days after the date of Service. Exceptions will be made if we receive documentation that you lacked legal capacity during that period. Payment of claims submitted by the Oregon state Medicaid agency or a prepaid managed care health services organization described in ORS 414.651 (i.e., a Coordinated Care Organization) will be made in accordance with ORS 743B.470, which establishes payment requirements for claims submitted by the Oregon state Medicaid agency.

Payment of all claims will be made within the time limits required by OAR 836-080-0235, the Oregon Division of Financial Regulation's administrative rule setting standards for prompt payment. Please send all claims to:

Medical, Mental Health and Substance Use Disorder claims:

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

Routine Vision claims:

Vision Service Plan
Attn: Claims Services
P.O. Box 385018
Birmingham, AL 35238-5018

6.1.2 Right of Recovery

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

excess benefit from any future benefit that otherwise would have been available to the affected Member(s) from us under any contract.

6.2 COORDINATION OF BENEFITS

IMPORTANT NOTE: Other health plan coverage can disqualify you from eligibility for a Health Savings Account (HSA). Please check with your tax accountant for more information.

This Coordination of Benefits (COB) section applies when a Member has health care coverage under more than one Plan. The term "Plan" is defined below for the purposes of this COB section. The order of benefit determination rules governs 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.

6.2.1 Definitions Relating to Coordination of Benefits

Plan

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

1. Plan includes: group and individual health 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; and group and individual insurance contracts and Subscriber contracts that pay or reimburse for the cost of dental care.
2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare Supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

This Plan

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

The order of benefit determination rules listed in section 6.2.2 determine whether This Plan is a Primary plan or Secondary plan when a Member has health care coverage under more than one Plan.

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

Allowable expense

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

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

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
2. If the Member is 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 the 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 the 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 than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
5. The amount of any benefit reduction by the Primary plan because the 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. These benefits are primarily in the form of Services through a panel of providers. These providers have been contracted with or employed by the Plan. Coverage for services provided by other providers is excluded. Exceptions will only be made in cases of emergency or if there is 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.

6.2.2 Order of Benefit Determination Rules

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

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan.
    1. Except as provided in Paragraph (2) below, a Plan that does not contain a COB provision that is consistent with the State of Oregon's COB regulations is always primary unless the provisions of both Plans state that the complying Plan is primary.
    2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network benefits.

B. 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.

C. Each Plan determines its order of benefits using the first of the following rules that apply:
    1. Non-Dependent or Dependent. The Plan that covers a Member other than as a Dependent, for example, as an employee, Subscriber or retiree is the Primary plan and the Plan that covers the Member as a Dependent is the Secondary plan. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Member as a Dependent; and primary to the Plan covering the Member as other than a Dependent (e.g., a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Member as an employee, Subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
    2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Member is a Dependent child 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.

d) For a Dependent child:

i. Who has coverage under either or both parents' plans and also has coverage as a Dependent under a spouse's plan, the rule in paragraph (5) applies.

ii. In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Subparagraph (a) to the Dependent child's parent(s) and the Dependent's spouse.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a Member as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same Member as a retired or laid-off employee is the Secondary plan. The same would hold true if a Member is a Dependent of an active employee and that same Member is a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
4. COBRA or State Continuation Coverage. If a Member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the Member as an employee, Subscriber or retiree or covering the Member as a

Dependent of an employee, Subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the Member the longer period of time is the Primary plan and the Plan that covered the Member the shorter period of time is the Secondary plan.
6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than we would have paid had we been the Primary plan.

6.2.3 Effect on the Benefits of This Plan

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

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

6.2.4 Right to Receive and Release Needed Information

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

6.2.5 Facility of Payment

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

6.2.6 Right of Recovery

If the amount of the payments made by us is more than we should have paid under this COB section, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the

benefits or services provided for the Member. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

6.2.7 Coordination with Medicare

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

In accordance with the "working aged" provisions of the Medicare Secondary Payer Manual, when the Employer Group's size is less than 20 employees, for Members who are entitled to and enrolled in Medicare Part A, and also enrolled in Part B, Medicare will be the primary payer and we will coordinate benefits as the secondary payer. If it is determined that the member is enrolled in Part A, but not enrolled in Part B, we will be the Primary payer for Part B benefits.

When the Employer Group's size is 20 individuals or more, Medicare will be considered the secondary payer if the Member is enrolled in Medicare.

Counting individuals for the Employer size:

- Employees counted in the Employer size include the total number of nationwide full-time employees, part-time employees, seasonal employees, and partners who work or who are expected to report for work on a particular day.
- Those not counted in the Employer size include retirees, COBRA-qualified beneficiaries and individuals on other continuation options, and self-employed individuals who participate in the Employer's group health plan.

Medicare disabled and end-stage renal disease (ESRD) patients: The rules above may not apply to disabled people under 65 and ESRD patients enrolled in Medicare; please see the Medicare website, Medicare.gov, for more information.

6.3 THIRD-PARTY LIABILITY/SUBROGATION

The following provisions will apply when you or any other Member has received Services for a condition for which one or more third parties may be responsible. "Third party" means any person other than the Member (the first party to the provisions of this Plan), and Providence Health Plan (the second party), and includes any insurance carrier providing liability or other coverage potentially available to the Member. For example, uninsured or underinsured motorist coverage, no-fault medical payments (auto, homeowners or otherwise), or other group insurance (including student plans) whether under the Member's policy or not, are subject to recovery by us as a third-party recovery. Failure by the Member to comply with the terms of this section will be a basis for us to deny any claims for benefits arising from the condition or to terminate the Member's coverage under this Plan as specified in section 9.3. In addition, you or the Member must execute and deliver to us and to other parties any document requested by us which may be appropriate to confirm or secure the rights and obligations of the Member and Providence Health Plan under these provisions.

6.3.1 Third-Party Liability/Subrogation and How It Affects You

Third-party liability refers to claims that are in whole or part the responsibility of someone besides Providence Health Plan or the Member. Examples of third-party liability are motor

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

If we make claim payments on any Member's behalf for any condition for which a third party is responsible, we are entitled to be repaid promptly for those payments, directly out of any recovery from the third party, including any settlement, award, verdict, payment or other monetary recovery.

"Subrogation" means that we may collect directly from the third party to the extent we have paid for third-party liabilities. Because we have paid for the Member's injuries, we, rather than the Member, are entitled to recover those expenses. Prior to accepting any settlement of the Member's claim against a third party, the Member must notify us in writing of any terms or conditions offered in settlement and must notify the third party of our interest in the settlement established by this provision.

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

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

6.3.2 Proceeds of Settlement or Recovery

Subject to paragraph 6.3.4 below, if for any reason we are not paid directly by the third party, we are entitled to reimbursement from the Member or the Member's heirs, legal representatives, beneficiaries or relatives, and we may request refunds from the medical providers who treated the Member, in which case those providers will bill the Member for their Services. To the fullest extent permitted by law, we are entitled to the proceeds of any settlement, award, verdict, or other payment that results in a monetary recovery from a third party, whether or not responsibility is accepted or denied by the third party for the condition, whether or not such monetary recovery is described by any person as something other than a recovery of medical expenses incurred by us, and whether or not the Member is alleged to have any fault, under principles of comparative negligence or otherwise. With respect to any workers' compensation recovery, we are entitled to the proceeds whether or not the loss is deemed to be compensable under the workers' compensation laws. We are entitled to

recover up to the full value of the benefits provided by us for the condition, calculated using our UCR charges for such Services, less our pro rata share of the Member's out-of-pocket expenses and attorney fees incurred in making the recovery. We are entitled to such recovery regardless of whether the Member has been fully compensated or "made whole" for the loss caused by the third party, and regardless of whether the Member has been partially compensated for such loss. We are entitled to first priority in repayment, over the Member and over any other person, for such charges.

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

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

6.3.3 Suspension of Benefits and Reimbursement

Subject to paragraph 6.3.4 below, after the Member has received proceeds of a settlement or recovery from the third party, the Member is responsible for payment of all medical expenses for the continuing treatment of the illness or injury that Providence Health Plan would otherwise be required to pay under this Plan until all proceeds from the settlement or recovery have been exhausted. If the Member has failed to reimburse us as required by this section, we are entitled to offset future benefits otherwise payable under this Plan, or under any future contract or plan with us, to the extent of the value of the benefits advanced under this section.

If the Member continues to receive medical treatment for the condition after obtaining a settlement or recovery from one or more third parties, we are not required to provide coverage for continuing treatment until the Member proves to our satisfaction that the total cost of the treatment is more than the amount received in settlement or recovered from the third party, after deducting the cost of obtaining the settlement or recovery. We will only cover the amount by which the total cost of benefits that would otherwise be covered under this Plan, calculated using our UCR charges for such Services, exceeds the amount received in settlement or recovery from the third party. We are entitled to suspend such benefits even if the total amount of such settlement or recovery does not fully compensate the Member for other damages, particularly including lost wages or pain and suffering.

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

6.3.4 Special Rules for Motor Vehicle Accident Cases

If the third party recovery is payable to you or any enrolled family member as the result of a motor vehicle accident or by a motor vehicle liability or underinsured insurer, the rules in paragraphs 6.3.2 and 6.3.3 above are modified as provided below.

Before the Plan will be entitled to recover under from a settlement or recovery, you or your enrolled Family Member must first have received full compensation for your injuries. The Plan's entitlement to recover will be payable only from the total amount of the recovery in excess of the amount that fully compensates for the injured person's injuries.

The Plan will not deny or refuse to provide benefits otherwise available to you or your enrolled Family Member because of the potential that a third party recovery may potentially be available against the person who caused the accident or out of motor vehicle liability or underinsurance coverage.

7. PROBLEM RESOLUTION

7.1 INFORMAL PROBLEM RESOLUTION

All employees of Providence Health Plan share responsibility for assuring Member satisfaction. If you have a problem or concern about your coverage, including benefits or Services by In-Network Providers or payment for Services by Out-of-Network Providers, please ask for our help. Your Customer Service representative is available to provide information and assistance. You may call us or meet with us at the phone number and address listed on your Member ID card. If you have special needs, such as a hearing impairment, we will make efforts to accommodate your requirements. Please contact us so we may help you with whatever special needs you may have.

7.2 MEMBER GRIEVANCE AND APPEAL

Definitions:

Adverse Benefit Determination

An Adverse Benefit Determination means a:

- Denial of eligibility for or termination of enrollment in this Plan;
- Rescission or cancellation of coverage under this Plan;
- Source-of injury exclusion, network exclusion, Annual benefit limit or other limitation on otherwise Covered Services;
- Determination that a health care item or service is Investigational or not Medically Necessary; or
- Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care.

Appeal

A type of Grievance that is a written request from a Member or an Authorized Representative of the Member requesting further consideration of an Adverse Benefit Determination.

Authorized Representative

An individual who by law or by the authorization of a Member may act on behalf of the Member.

Concurrent Care

An approved ongoing course of treatment to be provided over a period of time or for a specified number of treatments.

Grievance

A communication from a Member or an Authorized Representative of a Member expressing dissatisfaction with an Adverse Benefit Determination, without specifically declining any right to Appeal or review, that is:

- In writing, for an internal Appeal or an external review; or in writing or orally, for an expedited response or an expedited external review; or
- A written complaint submitted by a Member or an Authorized Representative of a Member regarding the:
    - Availability, delivery or quality of a health care service;
    - Claims payment, handling or reimbursement for health care services and, unless the Member has not submitted a request for an internal Appeal, the complaint is not disputing an Adverse Benefit Determination; or
    - Matters pertaining to the contractual relationship between a Member and Providence Health Plan.

7.2.1 Your Grievance and Appeal Rights

If you disagree with our decision about your medical bills or health care services, you have the right to an internal review. You may request a review if you have received an Adverse Benefit Determination. You may also file a quality of care or general complaint or Grievance with us. You may appoint an Authorized Representative to act on your behalf during your Grievance or Appeal. Please include as much information as possible including the date of the incident, the names of individuals involved, and the specific circumstances.

In filing a Grievance or Appeal:

- You can submit written comments, documents, records and other information relating to your Grievance or Appeal and we will consider that information in our review process.
- You can be represented by anyone of your choice at all levels of Appeal.

Request for Claim/Appeal File and Additional Information:

- You can, upon request and free of charge, have reasonable access to and copies of the documents, records and other information relevant to our decision, at any time before, during or after the appeal process. This includes the specific internal rule, guideline, protocol, or other similar criterion relied upon to make an Adverse Benefit Determination, as well as a copy of your claim or appeal file as applicable.
- You also have the right to request free of charge, at any time, the diagnosis and treatment codes and their meanings that are the subject of your claim or appeal.

Filing a Grievance or Appeal does not affect your right to receive benefits for Covered Services as otherwise provided under this Plan.

If you received the services that were denied in our Adverse Benefit Determination, and if the Adverse Benefit Determination is upheld by internal or external review, you will be financially responsible for any benefits paid by the Plan for such services pursuant to Oregon state law.

To the extent possible, Customer Service will resolve complaints filed by telephone at the point of service. We will acknowledge all non-urgent pre-service and post-service Grievances and Appeals within seven days of receipt and resolve within 30 days or sooner depending on

the clinical urgency. Urgent medical conditions and concurrent care have different resolution timelines as noted below.

Urgent Medical Conditions*:* If you believe your health would be seriously harmed by waiting for our decision on your Grievance or Appeal of a denied Prior Authorization or Concurrent Care request, you may request an expedited review by calling a Customer Service representative at 503-574-7500 or 800-878-4445 outside the Portland area. If your Appeal is urgent and qualifies for external review, you may request to have both your internal and external Appeal expedited at the same time. We will let you know by phone and letter if your case qualifies for an expedited review. If it does, we will notify you of our decision within 72 hours of receiving your request.

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

7.2.2 Internal Grievance or Appeal

You must file your internal Grievance or Appeal within 180 days of the date on our notice of the initial Adverse Benefit Determination, or that initial Determination will become final. The 180-day timeframe applies to both Standard and Expedited appeals. Please provide us any additional information that you want us to consider during our review process. If you are seeing an Out-of-Network Provider, you should contact the provider's office and arrange for the necessary records to be forwarded to Providence Health Plan. Your Grievance or Appeal will be reviewed by Providence Health Plan staff not involved in the initial determination. You may present your case in writing. Once a final determination is made, you will be sent a written explanation of the decision.

7.2.3 External Review

If you are not satisfied with your internal Grievance or Appeal decision, you have the right to an external review by an Independent Review Organization (IRO). The IRO will determine if your case qualifies for external review. To qualify for external review, the case must involve (a) Medically Necessary treatment, (b) Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care or (e) an exception to a prescription drug formulary. Your request must be made in writing within 180 days of receipt of the internal Grievance or Appeal decision, or that internal decision will become final. If you agree, we may waive the requirement that you exhaust the internal review process before beginning the External Review process. We will notify the Oregon Division of Financial Regulation within two business days of receiving your request for external review, at which point an IRO will be assigned to the case by the Oregon Division of Financial Regulation and we will forward complete documentation regarding the case to the IRO.

If you request an external review you must agree to authorize release of medical records needed by the IRO and submit any additional information to the IRO no later than five days after the appointment of the IRO, or 24 hours in cases of expedited review. The IRO is entirely independent of Providence Health Plan and performs its review under a contract

with the Oregon Division of Financial Regulation. The IRO will notify you and us of its decision within three days for expedited reviews and within 30 days when not expedited. **We agree to be bound by and to comply with the IRO decision.**

We pay for all costs for the handling of external review cases and we administer these provisions in accordance with the insurance laws and regulations of the state of Oregon. **If we do not comply with the IRO decision, we may be penalized by the Oregon Division of Financial Regulation, and you have the right to sue us under applicable Oregon law.**

7.2.4 Information Available Upon Request

We will provide, upon request, Annual summaries of Grievances and Appeals, utilization review policies, quality assessment activities, our health promotion and disease prevention activities, our scope of network and accessibility of services; and the results of all publicly available accreditation surveys.

7.2.5 How to Submit Grievances or Appeals and Request Appeal Documents

To submit your Grievance or Appeal, or to request our Annual reports, you may contact Customer Service at 503-574-7500 or 800-878-4445. If you are hearing impaired and use a Teletype (TTY) Device, please call our TTY line at 711. Written Grievances or Appeals should be sent to:

Providence Health Plan
Appeals and Grievance Department
P.O. Box 4158
Portland, OR 97208-4158

You may fax your Grievance or Appeal to 503-574-8757 or 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., Ste. 10
Beaverton, OR 97005

7.2.6 Assistance with your Grievance or Appeal

You may, at any time during the Grievance and Appeal process, seek assistance from the Oregon Division of Financial Regulation with your concerns regarding our decisions and benefits. You may contact the Oregon Division of Financial Regulation at:

Oregon Division of Financial Regulation
Consumer Protection Unit
P.O. Box 14480
Salem, OR 97309-0405

503-947-7984 (phone)
888-877-4894 (toll-free)
503-378-4351 (fax)

DFR.InsuranceHelp@oregon.gov (e-mail)
https://dfr.oregon.gov (website)

If your plan is governed by ERISA, you may contact the Employee Benefits Security Administration at 866-444-EBSA (3272). If your plan is not governed by ERISA, you may contact the Department of Health and Human Services Health Insurance Assistance Team at 888-393-2789.

8. ELIGIBILITY AND ENROLLMENT

This section outlines who is eligible for coverage, and how and when to enroll yourself and your Eligible Family Dependents. No benefits shall be available to anyone not enrolled under this Plan. You and your Employer must provide Providence Health Plan with evidence of eligibility as requested.

8.1 EMPLOYEE ELIGIBILITY AND ENROLLMENT

Employers decide when their employees are eligible for health care coverage. Your Employer may require you to work a certain length of time, called an Eligibility Waiting Period, before you qualify to enroll in the Plan. If an Eligibility Waiting Period exists, it will be outlined in the Employer/Group Agreement on file with your Employer.

8.1.1 Employee Eligibility Date

An employee is eligible for coverage when:

1. The eligibility requirements stated in the Employer/Group Agreement are satisfied;
2. The employee is an Eligible Employee; and
3. The employee meets the Service Area requirement stated in section 15 or the out-of-area Subscriber requirements of this Plan.

8.1.2 Employee Effective Date

The Effective Date of Coverage is usually the first day of the month following the completion of any Eligibility Waiting Period. Your Employer determines when coverage will begin.

8.1.3 Employee Enrollment

The Eligible Employee must enroll on forms provided and/or accepted by us. To obtain coverage, an Eligible Employee must enroll within the time period specified in the Employer/Group Agreement. Generally, an Employee has 30 days to enroll after becoming eligible.

If you decline coverage or fail to enroll when you first become eligible, the next earliest time you may enroll is the next occurring Open Enrollment Period.

In certain situations, you and/or your Eligible Family Dependents may qualify to enroll during a special enrollment period. See section 8.3 for additional information.

8.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

8.2.1 Eligibility Date

Most Plans allow Subscribers to enroll their Eligible Family Dependents. Eligible Family Dependents are described in section 14, Definitions. If your Plan includes coverage for Family Dependents, it will be indicated in the Employer/Group Agreement. Contact Customer Service or your Employer's benefits office to find out if your Plan includes coverage for Family Dependents.

Each Eligible Family Dependent is eligible for coverage on:

1. The date specified in the Employer Group/Agreement on file with your Employer for the newly Eligible Employee if the individual is an Eligible Family Dependent who may be covered on that date;
2. For any Eligible Family Dependents acquired on the date of the Subscriber's marriage, on the first day of the calendar month following our receipt of the enrollment request, or on an earlier date as agreed to by us;
3. The date of birth of the biological child of the Subscriber or Spouse;
4. The date a child is placed with the Subscriber or Spouse for the purpose of adoption or foster care by the Subscriber or Spouse;
5. The date the Subscriber or Spouse is required to provide health coverage to a child under a qualified medical child support court or administrative order; or
6. The date on which legal guardianship status begins.

8.2.2 Additional Requirements for Eligible Family Dependent Coverage

An Eligible Employee may cover Eligible Family Dependents ONLY if the Eligible Employee is also covered, and we receive the completed enrollment form requesting Dependent coverage.

8.2.3 Eligible Family Dependent Enrollment

You must enroll Eligible Family Dependents on forms provided and/or accepted by us. No Eligible Family Dependent will become a Member until we approve that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within the time period specified in the Employer/Group Agreement after becoming eligible as indicated in section 8.2.1 (see section 8.2.4 regarding newborn, newly adopted children, and new fostered children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period, as described in section 8.3.

8.2.4 Newborn, Newly Adopted Children, and Newly Fostered Children Eligibility and Enrollment

A newborn, newly adopted child, or newly fostered child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption or foster care as long as enrollment occurs within 60 days of the birth date or placement for adoption or foster care and the additional Premium, if any, is paid to us. If the enrollment and payment of additional Premium, if any, are not accomplished within this time period, no Services will be covered for the child. Enrollment after this time period may be accomplished as outlined in sections 8.2.3 and 8.3.

8.2.5 Open Enrollment Period

Your Employer will provide an Open Enrollment Period each Contract Year. The Effective Date of Coverage for new Members who enroll during the Open Enrollment Period is the first day of the Contract Year for which they enroll.

8.2.6 Changes in Eligibility

When an eligibility change occurs, you need to make sure we are notified of the change. Address changes can be made over the phone by calling Customer Service or by visiting our website.

For the following changes, you, as the Subscriber, must obtain an enrollment form from your Employer's benefit office. You need to submit this form to your Employer for you and all your Eligible Family Dependents when:

- You marry and wish to enroll your new Spouse;
- A Dependent's limiting age occurs; or
- You or one of your Dependents has a legal name change.

If you have questions regarding eligibility changes, please contact Customer Service.

8.2.7 Members No Longer Eligible for Coverage

If you divorce or are legally separated, your Spouse is no longer eligible for coverage as a Dependent. You must disenroll your Spouse as a Dependent from your Plan at the time the divorce or legal separation is final. Your Spouse's children will be able to continue coverage under the Plan so long as the children continue to qualify as your Eligible Family Dependents.

You must inform your Employer of these changes by completing a new enrollment form. Check with your Employer's benefits office or contact Customer Service to determine the effective date of any enrollment or disenrollment.

Those who no longer qualify as your Eligible Family Dependents may be eligible to continue coverage as described under section 10. Ask your Employer or call Customer Service for continuation coverage eligibility information.

8.3 SPECIAL ENROLLMENT PERIODS

If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your Spouse) during a previous enrollment period (as stated in sections 8.1 and 8.2), you may be eligible to enroll yourself or the Eligible Family Dependent during a "special enrollment period" provided that you request enrollment within 30 days of the qualifying event and meet the applicable requirements stated in this section.

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

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

8.3.1 Loss of Other Coverage

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

a) The person was covered under a group health plan or had other health coverage (includes benefits consisting of medical care under any hospital or medical services policy or certificate, or HMO) at the time coverage under this policy was first offered to the person; and
b) The person stated in writing that coverage under such group health plan or health coverage was the reason for declining enrollment; but only if we required such a

statement and provided the person with notice of such requirement (and the consequences of such requirement) at such time; and

c) Such coverage:
   - was under a COBRA Continuation provision and the coverage under such a provision was exhausted, except when the person failed to pay timely Premium, or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact); or
   - was not under a COBRA Continuation provision and the coverage was terminated as a result of:
     1. The individual's loss of eligibility for the coverage; including as a result of legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment; except when the person failed to pay timely Premium or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact); or
     2. The individual's loss of eligibility for coverage under the Children's Health Insurance Program (CHIP), Medicaid, Medicare, TRICARE, Indian Health Service or domestic or foreign publicly sponsored or subsidized health plan; including, but not limited to, the Oregon Health Plan (OHP); and the individual applies for coverage under this Plan within 63 days of the termination of such coverage; or
     3. The termination of contributions toward such coverage by the current or former Employer; or
     4. The individual incurring a claim that exceeds the lifetime limit on benefits; and the individual applies for coverage under this Plan within 30 days after the claim is denied.

Effective Date: Coverage under this Plan will take effect on the first day after the other coverage ended.

8.3.2 Position Change

If you are currently enrolled as a Subscriber and you experience a change in employment status that results in a change in the individual's eligibility for coverage under the group health plan, we will provide a "special enrollment period" during which you and your Eligible Family Dependents may change your enrollment to another plan.

The "special enrollment period" shall be 30 days beginning on the date of your employment change. Coverage shall be effective the first day of the calendar month following our receipt of the enrollment request.

8.3.3 New Dependents

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

The "special enrollment period" shall be a period of 30 days and begins on the later of:
- the date Dependent coverage is made available under this Plan; or
- the date of the marriage, birth, adoption or placement for adoption, or foster care.

Effective Date:

- in the case of marriage, on the first day of the calendar month following our receipt of the enrollment request, or on an earlier date as agreed to by us; or
- in the case of a Dependent's birth, on the date of such birth; or
- in the case of a Dependent's adoption or placement for adoption or foster care, the date of such adoption or placement for adoption or foster care; or
- in the case of legal guardianship of a Dependent, the date such legal guardianship status begins.

8.3.4 Newly Divorced

If you are currently enrolled as a Subscriber and you become newly divorced and your Employer offers more than one health benefit plan, we will provide a "special enrollment period" during which you and your Eligible Family Dependents may change your enrollment to another plan.

The "special enrollment period" shall be 60 days beginning on the date your divorce became final. Coverage shall be effective the first day of the calendar month following our receipt of the enrollment request, or an earlier date as agreed to by us.

8.3.5 Court Orders

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

Effective Date: The date specified in the court order.

8.3.6 Premium Assistance

If you or your Eligible Family Dependent were eligible to enroll under this Plan but did not enroll during a previous enrollment period, and you or your Eligible Family Dependent becomes entitled to group health plan premium assistance under a Medicaid-sponsored or Children's Health Insurance Program (CHIP)-sponsored arrangement, we will provide a "special enrollment period" for you and your Family Member(s) if you request enrollment within 60 days after the date of entitlement.

8.4 MEMBERS AFFECTED BY A REPLACEMENT OF GROUP COVERAGE

If you were covered under the Employer's prior group policy on the date of termination of that group policy and the Employer replaces that group policy with this Plan with no lapse in coverage and you are eligible for and enroll in coverage under this Plan, then the following will govern such coverage:

- The minimum level of benefits to be provided by us shall be the applicable level of benefits of this Plan reduced by any benefits payable by the prior contract or policy. Such coverage will be provided by us until the date on which your coverage terminates, as described in section 9.
- In applying any Deductibles, Out-of-Pocket Maximums, or benefit Exclusion Periods of the prior plan, we will credit any applicable Deductibles and Out-of-Pocket Maximums actually incurred by you and will credit the time period satisfied towards any

applicable benefit Exclusion Periods. This means the Deductible and Out-of-Pocket Maximum credit shall be given only to the extent the expenses are recognized under the terms of this Plan and are subject to a similar Deductible or Out-of-Pocket Maximum.

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

8.5 LEAVE OF ABSENCE AND LAYOFFS

A Subscriber on an Employer-approved leave of absence, for any reason, may continue to be covered under this Plan as though actively at work, at the Employer's option, for a period of time, as stated in the Employer/Group Agreement. Absences extending beyond this time period will be subject to section 10.

A Subscriber who has been laid off and rehired shall be covered, as stated in the Employer/Group Agreement. An enrollment application must be completed by the Eligible Employee and received by us within the time period stated in the Employer/Group Agreement.

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

- The Subscriber's absence must be within the Employer's policies and practices as defined in the Employer/ Group Agreement;
- The Employer's leave of absence policy must comply with the Oregon FMLA, the federal FMLA; or the USERRA;
- The Employer's work-related disability policy must comply with Workers' Compensation or similar laws; and
- The Employer must continue to pay the Subscriber's and any covered Dependent's monthly Premium to the health plan. However, the Subscriber may be responsible for paying a portion or all of his/her Premium amount to his/her Employer in accordance to the Employer's leave of absence or work-related disability policies and practices.

Coverage for a Subscriber and any Eligible Family Dependents may be continued while the Subscriber is on Employer-approved leave of absence or while away from work due to a work-related disability.

9. TERMINATION OF MEMBER COVERAGE

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

1. The date this Plan terminates;
2. The end of the period for which required Premium was due to us and not received by us;
3. The date stated in the Employer/Group Agreement when a Subscriber terminates employment with the Employer;
4. The date stated in the Employer/Group Agreement when a Subscriber no longer qualifies as a Subscriber;
5. The date stated in the Employer/Group Agreement when a Subscriber fails to pay required Premiums by the end of the grace period;
6. The date stated in the Employer/Group Agreement when a Member is no longer in an eligible class of persons as provided in the Description of Classes, as shown in the Employer/Group Agreement;
7. The date stated in the Employer/Group Agreement when a Member enters full-time military, naval or air service, except as provided under federal USERRA requirements or similar state laws;
8. The date stated in the Employer/Group Agreement when a Subscriber retires;
9. The last day of the month in which the Subscriber makes a written request for termination of coverage to be effective for the Subscriber or Member;
10. For a Family Member, the date the Subscriber's coverage terminates;
11. For a Family Member, the last day of the month in which the individual no longer qualifies as an Eligible Family Dependent;
12. For any benefit, the date the benefit is deleted from this Plan;
13. For a Member, the date of disenrollment from this Plan, as described in section 9.3;
14. For a Member, the date any fraudulent information is provided; or
15. For a Member, the date we discover any breach of contractual duties, conditions or warranties, as determined by us.

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

See section 7, Problem Resolution, for your Grievance and Appeal rights.

9.1 TERMINATION AND RESCISSION OF COVERAGE DUE TO FRAUD OR ABUSE

Coverage under this Plan, either for you or for your covered Dependent(s), may be rescinded (meaning your coverage is retroactively canceled) or terminated in case of a fraud or intentional misrepresentation of material fact by you or by your covered Dependent in obtaining, or attempting to obtain, benefits under this Plan.

If coverage is rescinded, the Plan will retain any money you paid for coverage as liquidated damages and will have the right to recover from you or from your covered Dependents the benefits paid as a result of such wrongful activity. We will provide all affected Plan participants with 30-day notice before rescinding coverage.

9.2 NON-LIABILITY AFTER TERMINATION

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

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

We will provide information to the Employer so the Employer can inform the Members of the termination of this Plan. It will be the Employer's responsibility to inform all Members that this Plan has terminated.

9.3 DISENROLLMENT FROM THIS PLAN

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

1. You have filed a false claim with us;
2. You willfully fail to provide information or documentation required to be provided under this Plan or knowingly provide incorrect or incomplete information; or
3. You have allowed a non-Member to use your Member ID Card to obtain Services.

9.4 PROOF OF PRIOR COVERAGE

- We will provide, upon request or as required by law, proof of prior coverage.

9.5 EMPLOYER'S RIGHT TO TERMINATE OR AMEND PLAN

Your Employer reserves the right at any time to terminate or amend in whole or part any of the provisions of the Plan or any of the benefits provided under the Plan. Any such termination or amendment may take effect retroactively or otherwise. In the event of a termination or reduction of benefits under the Plan, the Plan will be liable only for benefit payments due and owing as of the effective date of such termination or reduction and no payments scheduled to be made on or after such effective date will result in any liability to the Plan or your Employer.

10. CONTINUATION OF GROUP MEDICAL BENEFITS

If you become ineligible for coverage under this Plan you may, under certain circumstances, continue group coverage. There are specific requirements, time frames and conditions that must be followed in order to be eligible for continuation of group coverage and which are generally outlined below. Please contact your Employer as soon as possible for details if you think you may qualify for group COBRA or state continuation coverage.

10.1 STATE-MANDATED CONTINUATION COVERAGE

10.1.1 Groups with 20 or More Employees

If a surviving, divorced or legally separated Spouse of the Subscriber is at least 55 years old at the time of death or the dissolution or legal separation of the marriage; she or he may be eligible to continue coverage.

This state-mandated continuation of coverage will terminate upon the earliest of any of the following:

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

The covered Dependent children of the Spouse also remain eligible for coverage with the Spouse as long as they remain otherwise eligible under the terms of this Plan.

Obtaining Coverage

If you are a surviving Spouse eligible to continue coverage, within 30 days from the date of death of the Subscriber, the Employer must provide written notice of the death and the name and address of the surviving Spouse to the Employer's plan administrator.

If you are a divorced or legally separated Spouse eligible to continue coverage, within 60 days of the date of legal separation or judgment of dissolution of marriage, you must provide the Employer who sponsors this Plan with written notice of the divorce or legal separation, and include your mailing address. Within 14 days of receiving notice, the Employer or the Employer's plan administrator must provide you with written notice for electing continuation coverage. You will have 60 days from the date of this notice to elect coverage.

10.1.2 Groups Not Subject to COBRA (Groups with 19 or less Employees, and Groups with 20 or more Employees that are otherwise exempt from COBRA)

State-mandated continuation of coverage is available to you if you have been covered continuously under this Plan, or a similar predecessor group health plan, during the three-month period prior to the date of termination of employment or membership.

You may be eligible for continuation of coverage if:

1. Your coverage ends because of the termination of employment of the Subscriber; or
2. Your coverage ends because the Subscriber's reduction in work hours; or
3. Your coverage ends because the Subscriber becomes eligible for Medicare; or
4. Your coverage ends because or termination of membership under this Plan; or
5. Your coverage ends because of the death of the Spouse, the dissolution of the marriage, or a legal separation; or
6. In the case of Dependent children, when your children no longer meet Eligible Family Dependent requirements.

Obtaining Coverage

Within 10 days of receiving notification of a qualifying event, we will provide you with written notice for electing continuation coverage. You will have 10 days from the date of the qualifying event or 10 days from the date of the notice, whichever is later, to elect coverage.

Maximum Length of Coverage

State continuation of group coverage terminates the earlier of:

1. Nine months after the date on which the Subscriber's coverage under this Plan otherwise would have ended because of termination of employment or membership.
2. Nine months after the start of a leave of absence from which a Subscriber does not return to work.
3. Nonpayment: The end of the month for which you last made timely payment 30 days from the date the Premium is due.
4. Medicare: The first of the month in which you become entitled to Medicare benefits.
5. Other Group Coverage: The date you become eligible under another group health plan as a covered employee or as a Dependent.
6. Remarriage: The date the former Spouse remarries and, because of the remarriage, becomes eligible for coverage under another group health plan.

10.2 COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that applies to most Employers with 20 or more employees. Some Employers, such as church groups and state agencies, may be exempt from COBRA. The law requires that Employers subject to COBRA offer Employees and/or their Dependents continuation of medical and dental coverage in certain instances where there is a loss of group coverage.

10.2.1 Subscriber's Continuation Coverage

A Subscriber who is covered under this Plan may elect continuation coverage under COBRA if coverage is lost due to termination of employment (other than for gross misconduct) or a reduction in work hours.

10.2.2 Spouse's or Domestic Partner's Continuation Coverage

A Spouse or Domestic Partner who is covered under this 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 Subscriber;
- The termination of the Subscriber's employment (for reasons other than gross misconduct) or reduction in hours;
- The divorce or legal separation of the Subscriber and the Spouse;

- Termination of the domestic partnership; or
- The Subscriber becomes covered under Medicare.

10.2.3 Dependent's Continuation Coverage

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

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

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

10.2.4 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 this Plan. Under COBRA, you or your Family Member has the responsibility to notify your Employer 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 your Employer receives notification of one of the above "qualifying" events, you will be notified that you or your Family Member, as applicable, have 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 this Plan will be lost.

10.2.5 Type of COBRA Continuation Coverage

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

10.2.6 COBRA Election Rights

A Subscriber 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 Subscriber does not.

10.2.7 COBRA Premiums

If you are eligible for COBRA continuation coverage, you do not have to show that you are insurable (that you do not have any serious health conditions). However, you must pay the full Premium for your continuation coverage, including the portion of the Premium your Employer was previously paying, to your Employer. After you elect COBRA, you will have 45 days from the date of election to pay the first Premium. You must pay the Premium back to the point you would otherwise have lost coverage under this Plan. After that, you must pay

the Premium for each month as of the first of the month, and in all events within 30 days. If you fail to pay your monthly Premium, you will be notified that your coverage is being terminated.

10.2.8 Length of COBRA Continuation Coverage

18-Month Continuation Period

When coverage ends due to a Subscriber's termination of employment (other than for gross misconduct) or a reduction in hours, the continuation period for the Subscriber 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.

29-Month Continuation Period

If a qualified beneficiary 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 the Employer 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.

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

10.2.9 Extension of Continuation Period

If a second qualifying event occurs during the initial 18- or 29-month continuation period (for example, the 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 due to 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.

10.2.10 When COBRA Continuation Coverage Ends

COBRA Continuation coverage will end automatically for you and your Family Members when any of the following events occur:

- The Employer no longer provides health coverage to any employees;
- The Premium for the continuation coverage is not paid on time;
- The qualified beneficiary (employee, spouse or dependent child) later becomes covered under another health plan;
- The qualified beneficiary (employee, spouse, or dependent child) later becomes entitled to Medicare;
- The earliest date that the qualified beneficiary no longer qualifies for such coverage in accordance with the federal COBRA regulations; or
- The applicable maximum period of continuation coverage occurs.

10.2.11 Other Information

Please contact your Employer for any questions regarding COBRA continuation. Notify your Employer of any changes in marital status, or a change of address.

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

10.3 CONTINUATION OF BENEFITS DURING LABOR STRIKE

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

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

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

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

Coverage under this Plan shall be available to Subscribers who are not actively working and have filed a Workers' Compensation insurance claim. Premium contribution amounts/levels will be the same as if the Subscriber was actively at work and such Premium payments may be the responsibility of the Subscriber, in accordance with the policies of the Employer. This continuation of benefits is administered in accordance with the coverage extensions provision and with any state or federal continuation requirements. The Subscriber may maintain such coverage until the earlier of:

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

10.5 COVERAGE EXTENSIONS

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

11. MEMBER RIGHTS AND RESPONSIBILITIES

11.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES

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

Members have the right to:

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

Members have the responsibility to:

- Read and understand the information in and the terms of your Plan. We will have no 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 us. We will assist you in understanding and complying with the terms of the Plan.
- Talk openly with your physician or provider, understand your health problem and work toward a relationship built on mutual trust and cooperation.
- Develop mutually agreed upon treatment goals with your Qualified Practitioner, to the degree possible, and follow treatment plans and instructions.
- Supply to the extent possible information Providence Health Plan and your physicians or providers need to provide care.
- Do your part to prevent disease and injury. Try to make positive, healthful choices. If you do become ill or injured, seek appropriate medical care promptly.
- Treat your physicians or providers courteously.

- Make your required Copayment at the time of Service.
- Show your Member identification card whenever you receive medical Services.
- Let us know if you have concerns or if you feel that any of your rights are being compromised, so that we can act on your behalf.
- Call or write within 180 days of Service if you wish to request a review of Services provided or Appeal a Providence Health Plan decision.
- Notify Customer Service if your address changes.

Providence Health Plan has the responsibility to:

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

11.2 INFORMATION FOR ERISA MEMBERS (PARTICIPANTS)

The following information applies to Members (participants) who are covered by a plan that is subject to the federal ERISA (Employee Retirement Income Security Act of 1974) requirements for employee benefit plans. Typically, all Employer-sponsored plans except those sponsored by a state or local government entity or a church organization are subject to ERISA.

As a participant in your Employer's Group Plan, you are entitled to certain rights and protections under ERISA, which provides that all Plan participants are entitled to:

- Receive information about your Employer's Group Plan and benefits from the Plan administrator (your Employer)
    - Examine, without charge, at your Employer's offices, and at other specified locations, such as worksites, all plan documents, including insurance contracts and, if applicable, a copy of the latest Annual report (Form 5500) filed by your Employer with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
    - Obtain, upon written request to your Employer, copies of documents governing the operation of the Plan, including insurance contracts, the updated summary plan description and, if applicable, the latest Annual report (Form

5500). Your Employer or its plan administrator may make a reasonable charge for the copies.
    - Receive a summary of the Annual financial report for your Employer's Group Plan. Your Employer or its plan administrator is required by law to prepare and furnish each participant with this Summary Annual Report (SAR), but only if the plan covers 100 or more participants.
- Continue group health plan coverage
    - Continue health care coverage for yourself, Spouse or Dependents under the circumstances described in section 10.2 if, (a) there is a loss of coverage under the plan as a result of a qualifying event and, (b) your Employer has 20 or more employees. You or your Dependents may have to pay for such coverage. *(Please refer to section 10.2 for more information about COBRA.)*
- Prudent actions by plan fiduciaries
  In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of your Employer's group plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and the other plan participants and beneficiaries. No one, including your Employer, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.
- Enforce your rights
  If your claim for a plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules.

  Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest Annual report (Form 5500) from your Employer or their plan administrator and you do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require your Employer or their plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond their control.

  If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with a decision, or lack thereof, by your Employer or their plan administrator concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

  If it should happen that the fiduciaries of the plan misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim to be frivolous).
- Assistance with your questions
  If you have any questions about your plan, you should contact your Employer or their plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from your

Employer or their plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

11.3 INFORMATION FOR NON-ERISA MEMBERS (PARTICIPANTS)

The following information applies to Members (participants) who are covered by a plan that is not subject to ERISA.

As a participant in your Employer's Group Plan, you are entitled to certain rights and protections under Oregon law, which provides that all Plan participants are entitled to:

1. **Receive from us information maintained about you by your Employer's group plan**
    - You are entitled within 30 days to access to recorded personal information under ORS 746.640, provided you request it in writing and reasonably describe the information.
    - You may obtain copies, subject to paying a reasonable copying charge.
    - You are entitled to know to whom we may have disclosed any such information.
    - You are entitled to correct any errors in the information.
2. **Continue group health coverage**
    - Continue health care coverage for yourself, Spouse or Dependents under the circumstances described in section 10.1.
3. **Enforce your rights**

    If your claim for a plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules.

    As more fully described in section 7, we offer a Grievance process that attempts to resolve the concerns Members may have about claims decisions. No civil action may be brought to recover benefits from this Group Contract until receipt of a final decision under the Member Grievance and Appeal process specified in section 7.2 of this Group Contract. If the Member elects to seek external review under section 7.2.4, we will be bound by the Independent Review Organization (IRO) decision. No civil action may be brought later than three years after the date of the last decision rendered under the Member Grievance and Appeal process specified in section 7.2.

    Member's sole right of Appeal from a final Grievance determination, other than a determination referred for binding determination by an independent review organization, shall be to an Oregon state court, either in the Member's county of residence or such other county as mutually agreed upon between Member and the Plan. In the alternative, Member may request that the Plan agree to submit the dispute to binding arbitration before a single arbitrator appointed by the United States Arbitration & Mediation Service (USA&M) under Oregon law in the Member's county (unless otherwise mutually agreed) in accordance with USA&M's Rules for Arbitration. If arbitration is mutually agreed upon the arbitrator's decision shall be final and legally binding and judgment may be entered thereon. Irrespective of whether the Grievance is appealed to a court or an arbitrator, neither party shall

under any circumstance be liable to the other for any special, incidental, or consequential damages, or for any tort liability (including any punitive or exemplary damages), in any way related to this Group Contract.

12. GENERAL PROVISIONS

12.1 AMENDMENT OF THE GROUP CONTRACT

The provisions of the Group Contract may be amended, subject to receiving any required regulatory approval(s), by agreement between the Employer and us, or whenever Providence Health Plan reasonably deems such amendment necessary to maintain qualification of the Plan as a High Deductible Health Plan. Any such amendment shall become effective on the date specified in the amendment. The payment of Premium for any period of coverage after the effective date of an amendment shall constitute the acceptance of the amendment by the Employer if we have provided written notice of the amendment to the Employer prior to the payment of such Premium. Outside of renewal or as required by Oregon state or federal mandate, no material modification will be made to benefits, including preventive benefits, without providing notice to Members 60 days in advance of the effective date.

12.2 AVAILABILITY OF CONTRACT

The Employer shall maintain a copy of the Group Contract in a location and under circumstances in which it will be available for your reference. Additionally, we will provide access to a copy of the Group Contract to any Member upon request.

12.3 BINDING EFFECT

The Group Contract shall be binding upon and inure to the benefit of the heirs, legal representatives, successors and assigns of the parties hereto.

12.4 CIRCUMSTANCES BEYOND THE CONTROL OF PROVIDENCE HEALTH PLAN

If a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within our control results in the facilities, personnel, or financial resources of Providence Health Plan being unavailable to provide, or make arrangements for basic or supplemental health Service, then we are required only to make a good-faith effort to provide, or make arrangements for the Service, taking into account the impact of the event. For this purpose, an event is not within the control of Providence Health Plan if we cannot exercise influence or dominion over its occurrence.

12.5 CHOICE OF STATE LAW

The laws of the State of Oregon govern the interpretation of this Group Contract and the administration of benefits to Members, except as provided in the Employer Group Agreement. Oregon law will govern the interpretation of any requirements applicable to Members who are out-of-area or who reside out of the Service Area.

12.6 DUPLICATING PROVISIONS

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

12.7 FAILURE TO PROVIDE INFORMATION OR PROVIDING INCORRECT OR INCOMPLETE INFORMATION

Employers and Members warrant that all information contained in applications, questionnaires, forms, or statements submitted to us to be true, correct, and complete. If a Member or Employer willfully fails to provide information required to be provided under the Group Contract or knowingly provides incorrect or incomplete information, then the Member or Employer's rights may be terminated. See section 9.3 and the Employer/Group Agreement.

In addition, if an Employer fails to furnish information as required to be furnished under terms of the Group Contract, the Employer will indemnify, defend, save and hold harmless Providence Health Plan from any lawsuits, demands, claims, damages or other losses arising from the Employer's failure to inform us or Members of such required information.

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

12.8 HOLD HARMLESS

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

12.9 INTEGRATION

The Group Contract and any attached amendments, embodies the entire contract of the parties. There are no promises, terms, conditions or obligations other than those contained herein. The Group Contract shall supersede all other communications, representations or agreements, either verbal or written, between the parties.

12.10 LEGAL ACTION

No civil action may be brought under state or federal law to recover benefits from the Group Contract until receipt of a final decision under the Member Grievance and Appeal process specified in section 7.2 of the Group Contract, unless the Member's benefits under the Group Contract are subject to the Employee Retirement Income Security Act (ERISA), in which case the Member is permitted either to bring a civil action under ERISA in federal court after receiving a decision from the First Level of Appeal or to bring such an action after receipt of a final Grievance decision. An Appeal from a final Grievance decision may lie with an Independent Review Organization (IRO). In the event a right to IRO review exists and the Member elects to seek such a review, the IRO decision will be binding and final as indicated in section 7.2.4. No civil action under ERISA or otherwise may be brought later than three years after the date of the last decision rendered under the Member Grievance and Appeal

process specified in section 7.2. If ERISA does not apply (see section 11.3) the action must be brought in Oregon state court, either in the Member's county of residence or such other county as mutually agreed upon between Member and the Plan. In general, ERISA applies if this is an employer-sponsored plan, other than a government plan or church plan.

12.11 NON-TRANSFERABILITY OF BENEFITS

No person other than a Member is entitled to receive benefits under this Group Contract. Such right to benefits is nontransferable.

12.12 NON-WAIVER

No delay or failure when exercising or enforcing any right under this Group Contract shall constitute a waiver or relinquishment of that right, and no waiver or any default under this Group Contract shall constitute or operate as a waiver of any subsequent default. No waiver of any provision of this Group Contract 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.

12.13 NO RECOURSE FOR ACTS OF PROVIDERS

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

12.14 NOTICE

Any notice required of us under the Group Contract shall be deemed to be sufficient if mailed to the Subscriber at the address appearing in the records of Providence Health Plan. Any notice required of the Employer or you shall be deemed sufficient if mailed to the principal office of:

Providence Health Plan
P.O. Box 4327
Portland, OR 97208

12.15 PHYSICAL EXAMINATION AND AUTOPSY

We, at our own expense, shall have the right and opportunity to examine any Member when and as often as may be reasonably required during the pendency of any claim covered by the Group Contract. We also have the right to make an autopsy in case of death if not forbidden by law.

12.16 PREMIUM REBATES

Federal medical loss ratio (MLR) regulations require premium rebates if a minimum percentage of the Premium charged for the Contract Year is not spent on health care services. If applicable, we will issue a premium rebate in accordance with the federal MLR requirements directly to the Employer for any Members covered under this Group Contract. The Employer shall be responsible for distributing any premium rebates to Subscribers and shall assist us in documenting compliance with the MLR requirements.

12.17 PROFESSIONAL REVIEW AND RIGHT TO EXAMINE RECORDS

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

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

12.18 PRORATION OF BENEFITS

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

12.19 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.

12.20 SUGGESTIONS

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

12.21 WORKERS' COMPENSATION INSURANCE

This Group Contract is not in lieu of, and does not affect, any requirement for coverage under any Workers' Compensation Act or similar law.

13. SUPPLEMENTAL BENEFITS

This section provides additional information about the Supplemental Benefits that may be included with your Plan. **Not all Plans include Supplemental Benefits.**

What are Supplemental Benefits? Supplemental Benefits are any benefits purchased by your Employer in addition to your Providence Health Plan health care coverage. Examples include: Massage Therapy, Vision and Bariatric Surgery.

Do I have Supplemental Benefits? If your Plan includes Supplemental Benefits, the Benefit Summary(ies) included with you Member materials will describe your Supplemental Benefit Covered Services and applicable Deductibles, Copayments and Coinsurance.

13.1 MASSAGE THERAPY SUPPLEMENTAL BENEFIT

Coverage is provided for massage therapy, as stated in the Benefit Summary. To be eligible for coverage, all massage therapy Services must be Medically Necessary and within the Qualified Practitioner's scope of license.

13.2 VISION SUPPLEMENTAL BENEFIT

The Vision Supplemental Benefit provides coverage for routine Vision Services for Members. See your Benefit Summary for a description of your Vision benefits and Covered Services. Vision Services for Members 18 and under transition to adult benefits on the last day of the month of the Member's 19th birthday.

13.3 BARIATRIC SURGERY SUPPLEMENTAL BENEFIT

Coverage is provided In-Network for Medically Necessary bariatric surgery procedures for the treatment of morbid obesity in adults in accordance with the medical policy and criteria established and maintained by Providence Health Plan.

Prior Authorization is required for all bariatric surgery Covered Services. Approved surgical procedures are outlined in the medical policy and may be covered when medical necessity criteria is met. Services must be received at a Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) accredited center or PHS approved facility. To locate an approved facility, visit the MBSAQIP website at facs.org/search/bariatric-surgery-centers. Not all facilities are considered In-network, facilities must be verified by utilizing the provider directory at ProvidenceHealthPlan.com/findaprovider.

All approved bariatric surgery Services will be covered at the applicable benefit level, as shown in the Benefit Summary, for the type of Services received (e.g. Provider surgery Services are covered under the "surgery and anesthesia" Provider Services benefit, facility Services are covered under the "inpatient/observation care" Hospital benefit). Deductible, Copayment, and Coinsurance will apply.

14. DEFINITIONS

The following are definitions of important capitalized terms used in this Member Handbook.

Adverse Benefit Determination
See section 7.

Alternative Care Provider
Alternative Care Provider means a naturopath, chiropractor, acupuncturist or massage therapist 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.

Ambulatory Surgery Center
Ambulatory Surgery Center means an independent medical facility that specializes in same-day or outpatient surgical procedures.

Annual
Annual means once per Calendar Year.

Annual Limit on Cost-Sharing
See section 3.11.3.

Appeal
See section 7.

Approved Clinical Trial
Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment or cancer or other life-threatening disease or condition and is one of the following:

- A federally funded or approved trial;
- A clinical trial conducted under an FDA investigational new drug application; or
- A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Authorized Representative
See section 7.

Benefit Summary
Benefit Summary means the documents with that title that are part of your Plan and summarize the benefit provisions under your Plan.

Calendar Year
Calendar Year means a 12-month time period beginning January 1st and ending December 31st.

Cochlear Implant
See section 4.12.11.

Coinsurance

Coinsurance means the dollar amount that you are responsible to pay to a health care provider, after your claim has been processed by us. Your Coinsurance for a Covered Service is shown in the Benefit Summary and is a percentage of the charges for the Covered Service. Your Coinsurance will usually be less when you receive Covered Services from an In-Network Provider.

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:

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

Contract Year

Contract Year means a 12-month time period starting from the effective date of the Group Contract.

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 structures of the body in order to improve your appearance or self-esteem.

Covered Service

Covered Service means a Service that is:

- Listed as a benefit in the Benefit Summary and in section 4;
- Medically Necessary;
- Not listed as an Exclusion in the Benefit Summary or in sections 4 and 5; and
- Provided to you while you are a Member and eligible for the Service under this Group Contract.

Creditable Coverage

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

Custodial Care

Custodial Care means Services that:

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

Such Services will still be considered Custodial Care even if:

- You are under the care of a physician;
- The Services are prescribed by a Qualified Practitioner;
- The Services function to support or maintain your condition; or
- The Services are being provided by a registered nurse or licensed practical nurse.

Deductible

See section 3.11.1.

Diagnostic Breast Examination

Diagnostic Breast Examination means a medically necessary and appropriate examination of the breast, including an examination using diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound, that is used to evaluate an abnormality:

- Seen or suspected from a screening examination for breast cancer;
- Or detected by another means of examination.

Domestic Partner

A Domestic Partner is:

- At least 18 years of age; and
- Has entered into a domestic partnership; and
- Has legally registered a Declaration of Domestic Partnership and obtained a Certificate of Registered Domestic Partnership in accordance with Oregon state law.

Note: All provisions of this Group Contract that apply to a Spouse shall apply to a Domestic Partner.

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.

E-mail Visit

E-mail Visit (electronic provider communications) means a consultation through e-mail with an In-Network Provider that is, in the judgment of the In-Network Provider, Medically Necessary and appropriate and involves a significant amount of the In-Network Provider's time. An E-mail Visit must relate to the treatment of a covered illness or injury (see also section 4.3.3).

Effective Date of Coverage

Effective Date of Coverage means the date upon which coverage under this Group Contract commences for a Member.

Eligibility Waiting Period

Eligibility Waiting Period means the period of employment, as specified in the Employer/Group Agreement, that an otherwise Eligible Employee must complete before coverage will begin under the Group Contract. The Eligibility Waiting Period for a large Employer will not exceed 90 days. Coverage is effective on the earlier of the first day of the next month following the completion of the Eligibility Waiting Period. When the Eligibility Waiting Period is 90 days, coverage is effective on the 91st day. If an employee enrolls on a

special enrollment date, any period before such special enrollment is not an Eligibility Waiting Period.

Eligible Employee
An Eligible Employee is an employee of the Employer who meets the eligibility criteria stated in the Group Contract and Employer/Group Agreement.

Eligible Family Dependent (Dependent)
Eligible Family Dependent means:

1. The legally recognized Spouse or Domestic Partner of a Subscriber;
2. In relation to a Subscriber, the following individuals:
    - A biological child, step-child, legally adopted child, or legally fostered child;
    - An unmarried grandchild for whom the Subscriber or Spouse provides at least 50% support;
    - A child placed for adoption or foster care with the Subscriber or Spouse;
    - An unmarried individual for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support; and
    - A child for whom the Subscriber or Spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law.

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

The limiting age for each Dependent child is 26 and such children shall become ineligible for coverage on the last day of the month in which their 26th birthday occurs.

A covered Dependent child who attains the limiting age remains eligible if the child is:

1. Developmentally or physically disabled; and
2. Incapable of self-sustaining employment prior to the limiting age;

Proof of incapacity must be provided to us upon enrollment. For Eligible Family Dependents who become incapacitated while covered under the Group Contract, proof of incapacity must be provided within 60 days of reaching the Dependent child limiting age. Thereafter, we may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to us, the individual's coverage will not continue beyond the last date of eligibility.

Emergency Medical Condition
See section 4.5.1.

Emergency Medical Screening Exams
See section 4.5.1.

Emergency Services
See section 4.5.1.

Employer
Employer means a Small or Large Employer that is the sponsor of the Group Contract, or any related entity, as described in the Employer/Group Agreement. To be covered under the Group Contract, an individual Employer must meet the definition of Eligible Employee.

Employer/Group Agreement
Employer/Group Agreement means the document with that title which is part of the Group Contract and which specifies the eligibility and coverage provisions under the Group Contract.

Endorsement
Endorsement means a document that amends and is part of the Group Contract. Endorsements, if any, are identified in the Employer/Group Agreement.

Essential Health Benefits
Essential Health Benefits means the general categories of Services established under section 1302(b) of the Patient Protection and Affordable Care Act (PPACA) and applicable regulations:

- Ambulatory patient Services;
- Emergency Services;
- Hospitalization;
- Maternity and newborn care;
- Mental Health and Substance Use Disorder Services;
- Prescription drugs;
- Rehabilitative and habilitative Services and devices;
- Laboratory Services;
- Preventive and wellness Services and chronic disease management; and
- Pediatric Services, including dental and vision care.

Family Member
Family Member means an Eligible Family Dependent who is properly enrolled in and entitled to Services under the Group Contract. For the purpose of ORS 743.730 the term "Member" satisfies the definition of "enrollee."

Fertility Preservation
Fertility Preservation means the retrieval and storage of sperm and eggs where treatment of cancer conditions may cause irreversible infertility as determined by our medical policy.

Gender Dysphoria
Gender dysphoria refers to psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity.

Gene and Adoptive Cellular Therapy
Gene and Adoptive Cellular Therapies are techniques that replace or modify a person's genes or cells to treat or cure some cancers and genetic diseases.

Global Fee
See section 4.13.2.

Grievance
See section 7.

Group Contract
Group Contract means the documents issued by Providence Health Plan to the Employer and includes the provisions of the Employer/Group Agreement, Rate Summary, Member Handbook and Benefit Summaries, any Endorsements or amendments that accompany these documents, and those policies maintained by Providence Health Plan which clarify any of these documents.

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

Health Savings Account
Health Savings Account (HSA) means a tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses for you and/or your Family Members (also known as the account beneficiaries) in accordance with Section 223 of the Internal Revenue Code. Account beneficiaries must be enrolled in an HSA-Qualified High Deductible Health Plan to contribute to an HSA. See section 2.1 for more information on HSAs.

Hearing Aid
See section 4.12.11.

Hearing Assistance Technology
See section 4.12.11.

High Deductible Health Plan
High Deductible Health Plan (HDHP) means an HSA-Qualified Health Benefit Plan as defined in Section 223 of the Internal Revenue Code that qualifies for use with an HSA. See section 2.1 for more information on HDHPs.

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

Hospital
Hospital means an institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;
2. Has a physician or surgeon in regular attendance;
3. Provides continuous 24-hour-a-day nursing Services;
4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;

5. Is legally operated in the jurisdiction where located; and
6. Has surgical facilities on its premises or has a contractual agreement for surgical Services with an institution having a valid license to provide such surgical Services.

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

Independent Freestanding Emergency Department
Independent Freestanding Emergency Department means a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable state law; and
- Provides Emergency Services and described in section 4.5.1.

In-Network
In-Network means the level of benefits specified in the Benefit Summary for Covered Services that are provided by an In-Network Provider.

In-Network Provider
In-Network 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 Indian and Alaskan Native Members, Covered Services obtained through Indian Health Services are considered to be Covered Services obtained from an In-Network Provider.

Ineligible Person
Ineligible Person means any person who does not qualify as a Member under the Group Contract.

Investigational
Investigational means Services for which current, prevailing, evidence-based, peer-reviewed medical literature does not demonstrate the safety and effectiveness of the Service for treating or diagnosing the condition or illness for which its use is proposed. In determining whether Services are Investigational the Plan considers a variety of criteria, which include, but are not limited to, whether the Services are:

- Approved by the appropriate governmental regulatory body;
- Subject to review and approval of an institutional review board (IRB) or are currently offered through an approved clinical trial;
- Offered through an accredited and proficient provider in the United States;
- Reviewed and supported by national professional medical societies;
- Address the condition, injury, or complaint of the Member and show a demonstrable benefit for a particular illness or disease;
- Proven to be safe and efficacious; and
- Pose a significant risk to the health and safety of the Member.

The investigational status of a Service may be determined on a case-by-case basis. We will retain documentation of the criteria used to define a Service as Investigational and will make this available for review upon request.

Medically Necessary

Medically Necessary means Covered Services that are in the reasonable opinion of Providence Health Plan, consistent with the written criteria regarding medically indicated Covered Services that are maintained by us.

The criteria are based on the following principles:

1. Covered Services are determined to be Medically Necessary if they are health care services or products that a Qualified Practitioner, exercising prudent clinical judgment, would provide to a Member for the purpose of evaluating, diagnosing, preventing, or treating illness (including mental illness), injury, disease or its symptoms, and that are:
    a. In accordance with generally accepted standards of medical practice;
        i. Generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Qualified Practitioner specialty society recommendations, the views of Qualified Practitioners practicing in relevant clinical areas, and any other relevant factors;
    b. Clinically appropriate, in terms of type, frequency, extent, site and duration; and considered effective for the Member's medical condition;
    c. Not primarily for the convenience of the Member or Qualified Practitioner; and
    d. Not more costly than an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis, prevention or treatment of that Member's illness, injury or disease.

Prudent Clinical Judgment: The "prudent clinical judgment" standard of Medical Necessity ensures that Qualified Practitioners are able to use their expertise and exercise discretion, consistent with good medical care, in determining the Medical Necessity for health care Services to be provided to each Member. Covered Services may include, but are not limited to, medical, surgical, diagnostic tests, Substance Use Disorder treatment, other health care technologies, supplies, treatments, procedures, drug therapies or devices.

Member

Member means a Subscriber, Out-of-Area Subscriber, Out-of-Area Dependent or Eligible Family Dependent, who is properly enrolled in and entitled to Services under the Group Contract. For the purpose of ORS 743.730(13) the term "Member" means "enrollee."

Mental Health

Mental Health means any mental health disorder covered by diagnostic categories listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), such as, but not limited to, major depressive disorder, autism spectrum disorder, dissociative identity disorder, gender dysphoria, and Substance Use Disorder.

Open Enrollment Period

Open Enrollment Period means a period of at least 10 working days each Contract Year, agreed to by us and the Employer, during which Eligible Employees are given the opportunity to enroll themselves and their Eligible Family Dependents under the Plan for the upcoming Contract Year, subject to the terms and provisions as found in section 8.

Out-of-Network
Out-of-Network means the level of benefits specified in the Benefit Summary for Covered Services provided by Out-of-Network Providers.

Out-of-Network Provider
Out-of-Network Provider means an Outpatient Surgical Facility, Home Health Provider, Hospital, Qualified Practitioner, Qualified Treatment Facility, Skilled Nursing Facility, or Pharmacy that does not have a written agreement with Providence Health Plan to participate as a health care provider for this Plan.

Out-of-Pocket Maximum
See section 3.11.2.

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

Participating Pharmacy
Participating Pharmacy means a pharmacy that has signed a contractual agreement with Providence Health Plan to provide medications and other Services at special rates. There are four types of Participating Pharmacies:

1. Retail: A Participating Pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions.
2. Preferred Retail: A Participating Pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.
3. Specialty: A Participating Pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.
4. Mail-Order: A Participating Pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.

Premium
Premium means the monthly rates set by us as consideration for benefits offered under the Group Contract. Premium rates are subject to change at the beginning of each Contract Year.

Primary Care Provider
A Primary Care Provider is a Qualified Practitioner who specializes in family practice, general practice, internal medicine, or pediatrics; a nurse practitioner; or a physician associate practicing in collaboration with a primary care physician. Members may choose and self-refer to a physician specializing in obstetrics or gynecology, a nurse practitioner, a certified nurse midwife, or a physician associate specializing in women's health care as their Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Primary Care Provider.

Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Note: Not all Qualified Practitioners are Primary Care Providers. To obtain a listing of In-Network Primary Care Providers, please see the online Provider Directory or call Customer Service.

Prior Authorization

Prior Authorization or Prior Authorized means a request to us by you or by a Qualified Practitioner regarding a proposed Service, for which our prior approval is required. Prior Authorization review will determine if the proposed Service is eligible as a Covered Service or if an individual is a Member at the time of the proposed Service. To facilitate our review of the Prior Authorization request, we may require additional information about the Member's condition and/or the Service requested. We may also require that a Member receive further evaluation from a Qualified Practitioner of our choosing. Prior Authorization is subject to the terms and provisions of this Group Contract. More information about Prior Authorizations is stated in section 3.5.

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

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

Providence ExpressCare Virtual Visits

Providence ExpressCare Virtual Visits can be utilized for common conditions; such as sore throat, cough, or fever, etc. using Providence's web-based platform through a tablet, smartphone, or computer for same day appointments. Virtual Visits are with In-Network Providers who are contracted with Providence Health Plan to provide Providence ExpressCare Virtual. Benefits will apply, as shown in your Benefit Summary. See section 4.3.2 for more details.

Providence Health Plan

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

Qualified Practitioner

Qualified Practitioner means a physician, Women's Health Care Provider, nurse practitioner, naturopath, clinical social worker, physician associate, 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.

Rate Summary
Rate Summary means the document with that title which is part of this Group Contract and which summarizes the Premium provisions under this Group Contract.

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 functional impairment.

Retail Health Clinic
Retail Health Clinic means a walk-in clinic located in a retail setting such as a store, supermarket or pharmacy that treats uncomplicated minor illnesses and injuries.

Service
There are many types of Services. Services include health care procedures, surgery, discussion, advice, diagnosis, referral, and treatment. Services also include supplies, medicine, prescription drug, device or technology. You must receive services from a Qualified Practitioner.

Service Area
See section 15.

Skilled Nursing Facility
Skilled Nursing Facility means a convalescent or chronic disease facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) 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.

Spouse
Spouse means an individual who is legally married to the Subscriber in accordance with the laws of the country or state of celebration.

Subscriber
Subscriber means an Eligible Employee who:

a) works or resides in the Service Area; or
b) works and resides outside* the Service Area; and
c) is properly enrolled in accordance with our underwriting criteria and participation requirements.

*Subscribers in this category are considered Out-of-Area Subscribers.

Substance Use Disorder
Substance Use Disorder 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. Substance Use Disorder does not mean an addiction to, or dependency on tobacco, tobacco products or foods.

Supplemental Benefit

Supplemental Benefit means any benefit purchased by your Employer in addition to your medical health care and prescription drug coverage. Examples: Chiropractic Manipulation, Acupuncture, Massage Therapy, Vision and Bariatric Surgery. Not all Members have Supplemental Benefits. If your Plan includes coverage for Supplemental Benefits, your Member materials will include information about each Supplemental Benefit in a Benefit Summary.

Supplemental Breast Examination

Supplemental Breast Examination means a medically necessary and appropriate examination of the breast, including an examination using breast magnetic resonance imaging or breast ultrasound, that is:

- Used to screen for breast cancer when there is no abnormality seen or suspected; and
- Based on personal or family medical history, or additional factors that may increase the individual's risk of breast cancer.

Urgent Care

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

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

Usual, Customary and Reasonable (UCR)

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

When a Service is provided by an Out-of-Network Provider, UCR charges will be determined, in Providence Health Plan's reasonable discretion, 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 or region who have similar training and experience;
3. A fee which is based upon a percentage of the Medicare allowable amount;
4. A fee which is prevalent or which would not be considered excessive in a particular case because of unusual circumstances; or
5. The fee determined by comparing charges for similar Services to a regional or national database adjusted to the geographical area where the Service was performed.

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

Women's Health Care Provider

Women's Health Care Provider means an obstetrician or gynecologist, some Primary Care Providers and naturopaths (if they are licensed to provide obstetrical services), physician associate specializing in women's health, advanced registered nurse practitioner specialist in women's health, certified nurse midwife, or licensed direct entry midwife, practicing within the applicable lawful scope of practice.

15. SERVICE AREA

Service Area means the geographic area:

a) In Oregon, within which a group entity must be physically located in order to qualify as an Employer and recipient of the Group Contract.
b) In Oregon and Southwest Washington, within which Subscribers, other than Out-of-Area Subscribers, must work or reside.

In-Network Providers are located within the Service Area, as well as outside of the Service Area through our national network.

Service Areas include:

All ZIP codes in Oregon.

All ZIP codes in the following Washington counties:

Clark
Klickitat
Skamania

16. NON-DISCRIMINATION AND LANGUAGE ACCESS

16.1 NON-DISCRIMINATION STATEMENT

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, you can call us at 503-574-7500 or 1-800-878-4445 (TTY: 711).

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158
Email: PHPAppealsandGrievances@providence.org

If you need help filing a grievance, call us at 503-574-7500 or 1-800-878-4445 (TTY: 711) for assistance.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at *http://hhs.gov/ocr/office/file/index.html*.

Members of Oregon Plans may file a complaint with the Division of Financial Regulation at 1-888-877-4894 or visit https://dfr.oregon.gov/Pages/index.aspx.

16.2 LANGUAGE ACCESS INFORMATION

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-898-8174 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-898-8174 (TTY: 711).

Russian: ВНИМАНИЕ: Если Вы говорите по-русски, то Вам доступны услуги бесплатной языковой поддержки. Звоните 1-800-898-8174 (телетайп: 711).

Vietnamese: CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-800-898-8174 (TTY: 711).

Traditional Chinese: 注意：如果您說中文， 您可以免費獲得語言支援服務。請致電1-800-898-8174 (TTY: 711)。

Kushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-898-8174 (TTY: 711).

Farsi:
توجه :اگر به زبان فارسی صحبت میکنید، تسهیلات زبا ی ن به صورت رایگان به شما ارائه میشود .با 1-800-898-8174 (TTY: 711) تماس بگ رییید.

Ukrainian: УВАГА! Якщо Ви розмовляєте українською мовою, для Вас доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером 1-800-898-8174 (телетайп: 711).

Japanese: お知らせ: 日本語での通話をご希望の場合、言語支援サービスを無料でご利用いただけます。1-800-898-8174 (TTY: 711) まで、お電話ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-898-8174 (TTY: 711) 번으로 전화해 주십시오

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंले दनम्न भाषा सहायता सेवाहरू दन:शुल्क रूपमा उपलब्ध छन् । 1-800-898-8174 (TTY: 711) मा फोन गनुर्होस् ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii gratuite de asistență lingvistică. Sunați 1-800-898-8174 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Rufnummer: 1-800-898-8174 (TTY: 711).

Hmong: LUS CEEB TOOM: Yog tias koj hais lus Hmoob, cov kev pab txhais lus, muaj kev pab dawb rau koj. Hu rau 1-800-898-8174 (TTY: 711).

Cambodian: កំណត់សម្គាល់៖ ប ើសិនជាអ្នកនិយាយភាសាខ្មែរ
អាចម្ដនបសវាជំនួយខ្នកភាសាបោយមិនគិតថ្លៃពីបោកអ្នក។ សូមបៅទូរស័ពទបលម 1-800-898-8174 (TTY: 711)។

Laotian: ເຊີນຊາບ: ຖ້າວ່າທ່ານເວ ້າພາສາລາວ, ຈະມີການຊ່ວຍເຫ ຼືອ ດ້ ານພາສາ ໂດຍບ ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ 1-800-898-8174 (TTY: 711).

Providence Health Plan

Our Mission

As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Our Values

Compassion | Dignity | Justice | Excellence | Integrity

Questions? We're here to help.

Speak to one of our Customer Service representatives at 503-574-7500 or 800-878-4445 (TTY: 711), 8 a.m. to 5 p.m. (Pacific Time) Monday through Friday.

ProvidenceHealthPlan.com

Providence Health & Services, a not-for-profit health system, is an equal opportunity organization in the provision of health care services and employment opportunities.

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