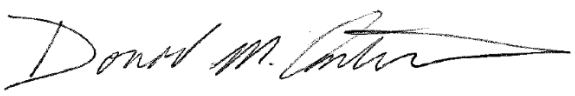
Providence
Health Assurance

GROUP MEDICARE CERTIFICATE OF COVERAGE

FOR PROVIDENCE GROUP MEDICARE SUPPLEMENT (MEDIGAP) PLAN A

If you need help understanding the terms in this document, please refer to the "Definitions" section, or contact Customer Service by dialing (971) 345-4013 or 1-888-231-9287, if you are hearing impaired and using a TTY device, please call 711. Office hours are Monday through Friday, 8 a.m. to 5 p.m.

NOTICE TO BUYER: This contract may not cover all of your medical expenses. Please carefully review all contract limitations.



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PROVIDENCE HEALTH ASSURANCE QUICK REFERENCE GUIDE

Resource	Contact Information
Customer Service Available Monday–Friday 8 a.m. to 5 p.m. (Pacific Time)	(971) 345-4013 (local) 888-231-9287 (toll-free) 711 (TTY) ProvidenceMedicareSupplement.com/group
Providence Nurse Advice Line	(503) 215-6755 (local) 888-989-3192 (toll-free)
Medicare Information	https://www.medicare.gov/Pubs/pdf/10050-Medicare-and-You.pdf
Medigap / Medicare Supplement Information	https://www.medicare.gov/02110-medigap-guide-health-insurance.pdf

WELCOME TO PROVIDENCE HEALTH ASSURANCE

Thank you for choosing Providence Health Assurance as your Group Medicare Supplement insurer. We are here to help you with your health insurance needs and we welcome any questions you may have about your contract.

This document summarizes the most important features of your group sponsored coverage. Your group sponsor has a copy of the full Group Contract, which you may inspect.

This Contract explains your Providence Group Medicare Supplement benefits, exclusions, limitations, and the terms and conditions of coverage. This Contract consists of this document, the Outline of Medicare Supplement Coverage, and any attached endorsements or amendments.

Important terms used in this Contract appear throughout this document and are capitalized for easier identification. The definitions for these terms appear at the end of this document in the "Definitions" section.

We want you to understand how to use your Providence Group Medicare Supplement 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
- Enrollment issues
- Questions or concerns about your health care or service

For assistance, please call us Monday through Friday between 8 a.m. and 5 p.m. (Pacific Time)

- (971) 345-4013
- 888-231-9287
- For hearing impaired and using a TTY device, please call 711

Please submit written communication to:
Providence Group Medicare Supplement
PO Box 14590
Salem, OR 97309

MEMBER RIGHTS AND RESPONSIBILITIES

As a Member of Providence Health Assurance, 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 Assurance, 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 Assurance, 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 Assurance.
- 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 Assurance's Member rights and responsibilities contract.
- Refuse care from specific providers.

Members have the responsibility to:

- Read and understand the information in and the terms of your Group Contract. 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 customer service or your employer's benefit administrator. 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 Assurance 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 Assurance decision.
- Notify Customer Service if your address changes.

Providence Health Assurance 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.
- Make it easy and convenient for you to Appeal any contract or decision that you believe prevents you from receiving appropriate care.
- Provide you with accurate and up-to-date information about Providence Health Assurance.
- 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 according to law.
- Ensure that your interests are well represented in decisions about Providence Health Assurance contract and governance.
- Encourage physicians and providers to make medical decisions that are always in your best interest.

YOUR MEMBER ID CARD

Every Providence Group Medicare Supplement Plan Member receives a Member ID Card. Your Member ID Card lists information about your health plan coverage, including:

- Your Member number
- Important phone numbers

The Member ID Card is issued by Providence Health Assurance for Member identification purposes only. It does not confer any right to services or other benefits under this Group Medicare Supplement Contract.

When scheduling an appointment or receiving health services, identify yourself as a Providence Group Medicare Supplement Plan Member, and present your Member ID Card.

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

- Visit your health care Provider or facility
- Call or correspond with Customer Service
- Call Providence RN medical advice line
- Receive immediate, urgent, or Emergency Care services

VALUE-ADDED SERVICES

In addition to your Medicare benefits, Providence Health Assurance offers optional value-added services that are not a part of your Medicare benefits. Our value-added services include access to a nurse advice line, One Pass's fitness program at no cost to you, and discounts on hearing aids (TruHearing) and meal delivery (Mom's Meals).

PROVIDENCE NURSE ADVICE LINE

(503) 215-6755 (local); 888-989-3192 (toll-free); TTY 711

The Providence nurse advice line is a free medical advice line for Providence Health Assurance 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 questions about how to treat common conditions such as flus, colds, or backaches. After a brief recorded message, a registered nurse will be available to assist you.

Please have your Member ID card available when you call.

FITNESS PROGRAM

Upon enrollment, all Members have access to the One Pass fitness program at no cost. The program offers a single membership at one of over 26,000 gyms and boutique fitness studios, with the ability to change locations anytime. You also have access to live virtual classes and social activities within local communities. Call 1-877-504-6830 (TTY: 711) or visit www.YourOnePass.com to learn more.

This program does not cover expenses for supplements, over-the-counter products, fees for fitness devices, or other health-related products recommended by a fitness center or health and exercise plan.

If this benefit ends, we will send a letter notifying Members at least 30 days prior to its termination.

HEARING AID DISCOUNT

Upon enrollment, all Members can save on hearing exams and get discounts on over 200 hearing aid models from top hearing aid manufacturers through our partner TruHearing. Prices and discounts vary by product. TruHearing also offers a 60-day trial period, one year of follow-up visits, and 80 free

batteries per non-rechargeable hearing aid. Call 1-855-204-8584 or visit TruHearing.com/Providence-HS to learn more.

If this benefit ends, we will send a letter notifying Members at least 30 days prior to its termination.

MOM'S MEALS DISCOUNT

Upon enrollment, Mom's Meals offers all Members discounts on nutritionally balanced meals delivered direct to their home. Mom's Meals delivers refrigerated meals that are ready to eat after heating for two minutes. Members pay $7.99 per meal or $8.99 per meal for Pureed, Renal, and Gluten Free (shipping included). Orders are shipped in coolers of 10, 14, or 21 meals. Place orders at 1-877-347-3438 or online at momsmeals.com/ProvMs and use promotion code ProvMS.

HOUSEHOLD PREMIUM DISCOUNT

You may be eligible for a discount of up to 20% off your monthly premium if you (1) are married or live with a domestic partner or adult at the same physical address, or (2) have lived with at least one, but no more than three, other adults 18 years of age or older in the last 12 months at the same physical address. The household discount is not available to those living in a one-person household, or in an assisted living facility.

DISCLOSURES

The following is a brief outline of key provisions of your Group Medicare Supplement Contract.

- Some capitalized terms have specific meanings in this contract. Please see the Definitions section (page 23).
- In this document, Providence Health Assurance is referred to as "we," "us" or "our". Members enrolled under this Group Contract are referred to as "you" or "your".
- In this document, your Group Medicare Supplement Contract is referred to as "Medicare Supplement" or "Supplement".
- Coverage under this Group Medicare Supplement Plan is available 24 hours a day, seven days a week and during periods of domestic travel (see note below).
- The Group Contract for this Group Medicare Supplement Plan includes this document (Certificate of Coverage), the Outline of Coverage, any endorsements or amendments that accompany those documents, and those policies maintained by Providence Health Assurance 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) Group Medicare Supplement contract, (3) Outline of Coverage, and (4) applicable Providence Health Assurance policies.

Note: Except in limited situations, Medicare does not pay for health care services you receive outside the U.S.

ELIGIBILITY

Eligibility for Group Medicare Supplement coverage is determined by the Centers for Medicare and Medicaid Services (CMS) and group eligibility requirements. In addition to meeting the group eligibility requirements specified in your Plan Sponsor's Group Contract, coverage is available to individuals who:

- Are enrolled in Medicare Part A (Hospital) and Part B (Medical) by reason of age (65 or older) or disability;
- Permanently reside in the United States;
- Are enrolling through a Plan Sponsor domiciled in the state of Oregon; and
- Become eligible for Medicare due to age, disability, or end-stage renal disease

ENROLLMENT AND DISENROLLMENT

If the Plan Sponsor is delayed in forwarding a completed application/enrollment to Providence Health Assurance, the Plan Sponsor may request a retroactive enrollment of up to 90 days in accordance with the following provisions:

- Providence Health Assurance must receive the fully complete application/enrollment form no more than 90 days after the requested Effective Date of Coverage
- The Effective Date of Coverage shall not occur prior to the date of signature on the application/enrollment form

Members wishing to disenroll from this group coverage must submit a written disenrollment request to the Plan Sponsor. Disenrollment will take effect as specified in the disenrollment confirmation letter that Providence Health Assurance provides to the Member.

SELECTING A PROVIDER

This Plan is an open-network Plan, which means that Members may obtain services from Medicare-approved Physicians/Providers and facilities of their choice. Additional details can be found below in the Claims Administration and Payment section of this document.

GENERAL EXCLUSIONS FOR PLAN A

This Group Medicare Supplement Plan will not provide benefits for:

Benefits available from other sources: To the extent that a Member can recover any expenses through a federal, state, county or municipal law or private medical insurance. This exclusion does not apply to Medicaid.

Care provided without charge: For stays, care, or visits for which no charge would be made to a Member in absence of insurance.

Dental care: Except for those services covered under Medicare.

Duplicate benefits: In no event will medical payment under this Plan duplicate any amounts payable under Medicare.

Eyeglasses and hearing aids: Including the purchase of eyeglasses or hearing aids, or the examination for the prescribing, fitting, or changing of eyeglasses or hearing aids, unless determined eligible by Medicare.

Home recovery care: Such as short term at home assistance provided by a home health aide, homemaker, personal care aide, or nurse for activities of daily living. Activities of daily living include but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

Outpatient prescription drugs and medicines: With or without a prescription. This exclusion does not apply to drugs and medical supplies and devices that are covered under Part A or Part B of Medicare.

Personal service items: Such as TVs, newspapers, telephones, or guest meals.

Preventive medical care: All preventive medical care unless such care is covered under Part B of Medicare.

Private nurses: Services of special private duty nurses are excluded unless such services are covered under Part B of Medicare.

Psychiatric Care which exceeds Medicare's psychiatric lifetime limitations or maximums: The Psychiatric Care benefit is administered in accordance with Medicare's rules and regulations, which state Medicare pays up to 190 days of inpatient care in a Medicare-certified psychiatric facility during your lifetime.

Services and supplies not recognized as a claim under Medicare.

Services provided before the effective date or after the termination date: Part A or Part B Medicare Eligible Expenses that began before the Member's Effective Date of Coverage or after the termination date under the Contract is not covered.

Services received from ineligible institutions: Such as services provided and billed by boarding homes, intermediate care facilities, homes for the aged, homes for drug addicts or alcoholics, schools or halfway houses, or services by any members of their staff.

Services received in government hospitals: Including any services or supplies furnished by the Veterans Administration or by any institution that is owned or run by a federal, state, county, or municipal government, unless payment of the charge under the Contract is required by law.

CLAIMS ADMINISTRATION AND PAYMENT

HOSPITAL BENEFITS AFTER COVERAGE STOPS

If the Group Contract is terminated, coverage for all Members ends on the effective date of termination. However, if a Member is in the Hospital on the day the Group Contract terminates, this Plan will continue to pay toward covered facility expenses for that Hospital stay until the Member is discharged from the Hospital or the Member's Plan benefits have been exhausted, whichever comes first. This is the only situation in which this Plan will pay toward an expense incurred while a Member is not insured under this Plan.

SUBMITTING CLAIMS TO MEDICARE FIRST

Before Providence Health Assurance can pay any benefits for expenses covered under this Plan the Member's treating Provider must file a claim for those expenses with Medicare. Typically, these claims are submitted to us from Providers on your behalf and you are not requested to initiate the process. Providence Health Assurance must receive confirmation from the Medicare carrier or intermediary that details the Medicare Eligible Expenses on a Medicare Explanation of Benefits (EOB). Only those charges determined by Medicare to be Medicare Eligible Expenses will be covered.

To submit a claim, mail the claim and Medicare EOB to:

Providence Health Assurance
Attention: Claims Department
PO Box 14590
Salem, OR 97309

TIME LIMITS FOR SUBMITTING CLAIMS

Providence Health Assurance recommends that Members submit their claims, along with the EOB, within 90 days of service or as soon as reasonably possible. However, claims, along with the EOB, can be submitted up to 12 months after the date of service. Providence Health Assurance will make no payments for claims received more than 12 months after the date of service, with the following exceptions consistent with Medicare timely filing guidelines:

- Administrative error
- Retroactive Medicare entitlement involving state Medicaid agencies
- Retroactive disenrollment from a Medicare Advantage Plan (MA)
- Retroactive disenrollment from a program of All-inclusive Care of the Elderly (PACE)

If a Member is billed directly and pays for benefits which are covered by this Plan, reimbursement from the Plan will be made upon the Member's written notice to the Plan of the payment.

Claim forms are available at ProvidenceHealthPlan.com/forms.

PAYMENT OF CLAIMS

All benefits payable under this Plan, except for benefits for Emergency Care in a foreign country, will be paid to whoever received the Medicare payment.

The service Provider must accept the Plan's payment as payment in full and may not bill the Member for any amounts over the Medicare Deductible and Coinsurance. There is an exception for some Providers, such as specialists who are allowed to bill 15 percent above Medicare's Approved Amount for medical procedures. The 15 percent difference between the Medicare-Approved Amount and the higher charge is also known as a Limiting Charge.

Benefits for emergency medical care in a foreign country are payable to the Member in United States currency in an amount based on the bank transfer exchange rate in effect on the day the services were received. For more information on emergency medical care in a foreign country, please refer to the "Emergency Medical Care in a Foreign Country" section of this document.

Providers must accept the issuer's payment as payment in full and may not bill the insured forany balance.

Upon exhaustion of the Medicare Hospital inpatient coverage, including the Lifetime Reserve Days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days.

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment, which may be prescribed herein and effective at the time of payment. If no such designation or provision is in effect, such indemnity shall be payable to the estate of the insured.

Indemnities payable under this contract will be paid immediately upon receipt of written proofof loss. Losses for which this contract provides periodic payment will be paid on a biweekly schedule.

CLAIMS PAID IN ERROR

If Providence Health Assurance pays a claim in error, Providence Health Assurance has the right to recover the payment from the party or facility paid.

APPEALS

Please refer to the Grievance and Appeals section of this document for information on appealing claim payments or claim denials.

MEDICARE AS SECONDARY PAYOR

If Medicare becomes a secondary payor for a Member who has benefits from another primary plan (for example, the Member has active employee coverage), **NO BENEFITS ARE PAYABLE UNDER THIS PLAN. (This exclusion does not apply to Medicaid.)**

PROBLEM RESOLUTION

INFORMAL PROBLEM RESOLUTION

All employees of Providence Health Assurance share responsibility for assuring Member satisfaction. If you have a problem or concern about your coverage, including benefits or services by Providers, please ask for our help. Your Customer Service representative is available to provide information and assistance. You may call 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 for help with any special needs you may have.

FORMAL PROBLEM RESOLUTION

If a Member has a Grievance (complaint) about Providence Health Assurance (for example, dissatisfaction with Providence Health Assurance's customer service), he/she has the right to file a Grievance in writing. If Providence Health Assurance denies all or part of a claim, a Member has the right to file an Appeal. A formal complaint, Grievance or Appeal must be submitted in writing. All quality-of-care issues must also be formally submitted in writing.

Filing a Grievance

Members should file a Grievance within 180 days of the occurrence that led to the Grievance and should include all the relevant information, including the date of the incident, the names of the individuals involved, and the specific circumstances.

Providence Health Assurance will respond to a Grievance, in writing, within 30 days.

Filing an Appeal (Overview)

If Providence Health Assurance denies all or part of a claim that a Member believes is a covered service under this Plan, the Member has the right to file an Appeal. Appeals must be submitted within 180 days of the date on the payment or denial letter to qualify for review. This timeline may be extended if Providence Health Assurance receives proof of the Member's legal incapacitation. Any additional information that was not available at the time the claim was reviewed should be included with the Appeal.

Providence Health Assurance will send a written notice of the Appeal decision within 60 days. If a more complete review is necessary, Providence Health Assurance may take up to 120 days, but Providence Health Assurance will notify the Member of that circumstance within 60 days.

How to Submit Grievances and Claims Appeals

Members may contact our Customer Service Team at (971) 345-4013 or 888-231-9287. For hearing impaired users using a TTY device, please call 711. Formal Grievances and written Appeals should be sent to:

Providence Health Assurance
Appeals and Grievance Department
PO Box 4158
Portland, Oregon 97208-4158

In addition, Members may fax a Grievance or Appeal to (503) 574-8757 or 1-800-396-4778.

External Review

If your Appeal involves (a) medically necessary treatment, (b) experimental investigational treatment, (c) an active course of treatment for purposes of continuity of care, or (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care, you may waive your right to internal Appeal and request an external review by an Independent Review Organization. Your request for external review must be made to Providence Health Assurance in writing within 180 days of the date on the Medicare Explanation of Benefits, or that decision will become final.

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
PO 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)

Members may also seek assistance from Senior Health Insurance Benefits Assistance (SHIBA) at the Oregon Insurance Division by calling 1-800-722-4134 or by contacting them through their website at https://shiba.oregon.gov/Pages/index.aspx.

For Grievances that involve Medicare coverage itself, Members should call Medicare directly at 1-800-MEDICARE (1-800-633-4227).

SERVICE AREA

Members are eligible to move anywhere within the United States if the group eligibility requirements have been met.

CONTINUATION OF COVERAGE

If your Group Contract is terminated by the Plan Sponsor and the Plan Sponsor does not replace this coverage with another Group Medicare supplement contract from us or another insurer, Providence Health Assurance shall offer all Members who are affected by the termination of group coverage, the opportunity to elect coverage as a Medicare Supplement Continuation Member and continue this Plan, with no interruption in coverage, at the filed and approved premium rates.

TERMINATION OF MEMBER COVERAGE

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

- The date the Group Contract terminates;
- The end of the period for which required premium was due to Providence Health Assurance and is not received by Providence Health Assurance;
- The last day of the month in which a Member does not maintain their enrollment under both Parts A and B of Medicare;
- The date stated on the Group Agreement when an individual no longer qualifies as an eligible individual;
- The date stated, if applicable, on the Group Agreement when a Member is no longer in an eligible class of persons;
- The end of the month in which a Member requests termination of their coverage to be effective;
- The date on which any fraudulent information is provided by a Member that affects his/her eligibility or benefits under this Group Contract; or
- The date on which Providence Health Assurance discovers any breach of contractual duties, conditions, or warranties by a Member, as determined by Providence Health Assurance.

Termination of a Group Medicare Supplement contract shall be without prejudice to any continuous losswhich commenced while the contract was in force.

PREMIUMS, RENEWAL, REVISION, RESCISSION, AND REINSTATEMENT

PREMIUMS

Premium Billing Information

Providence Health Assurance will provide a monthly premium billing statement to the employer and/or the entities responsible for payment listing the amount of premium due.

Changes in Premium Charges

The premium may be changed only in accordance with the following provisions:

- The premium is subject to change upon renewal of this Group Contract for another plan year.
- If at any time during a plan year any federal or state law or any order or regulation of a federal or state agency mandates a modification of benefits under this Group Contract, we may change the premium and/or covered services accordingly and you will be notified of this change in writing. The change in premium shall be effective on the effective date of the modification of benefits, as stated in the notice.

PREMIUM PAYMENT DUE DATE

Premium payment from the Plan Sponsor or responsible party is due on the first of the month, unless otherwise stated in the Group Agreement. If the premium is not paid within 15 days after the due date, we will mail a maximum of two premium delinquency notices to the Plan Sponsor and/or responsible party. If the Plan Sponsor does not pay the premium by the last day of the grace period specified in the notices, coverage will be retroactively terminated on the last day of the monthly period through which premiums were paid. We reserve the right to suspend claims processing for Plan Sponsors whose premiums are delinquent. Failure to pay the premium includes making a partial payment of the amount due as premium. The Plan Sponsor shall notify Members of the termination of coverage. If we fail to send the premium delinquency notice specified above, we will continue the Group Contract in effect, without payment of premium, until we provide such notice.

DOCUMENTATION OF MEMBER TERMINATION

It is the responsibility of the Plan Sponsor to notify us when the Plan Sponsor takes action to terminate the coverage of a Member under this Group Contract. Such notice shall be provided to us within 30 days following the termination date and shall consist of the following documentation:
(a) Members terminated for non-payment of premium contributions to the Plan Sponsor: A copy of the termination letter sent to the Member by the Plan Sponsor.
(b) Members who request termination of coverage: A copy of the Member's written request for termination of coverage.

If the Plan Sponsor fails to provide the documentation specified in this section, the Plan Sponsor, or responsible party shall be liable for payment of the required premiums for the affected Members until such documentation is received by us.

NONPAYMENT OF PREMIUM & COVERAGE REINSTATEMENT

If your group sponsored coverage terminates due to your nonpayment of your portion of the premium, you will be unable to reinstate coverage, except as mutually agreed by the Plan Sponsor and Providence Health Assurance.

RENEWAL AND REVISION

This Group Contract is guaranteed renewable and will not be terminated due to claims experience, health status, or length of time in force. Once you are enrolled in a Group Medicare Supplement Plan, it renews every year if you pay your premium, and the Plan is available.

RESCISSION (CONTRACT CANCELLATION)

Disenrollment from this Plan Contract

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

- Filing false claims with us;
- Allowing a non-Member to use your Member ID card to obtain services; or
- Providing false information on your application for coverage or on any subsequent form requesting a change to your coverage.

Termination and Rescission of Coverage Due to Fraud or Abuse

Your coverage under this Contract may be rescinded (meaning your coverage is retroactively canceled) or terminated in case of a fraud or intentional misrepresentation of material fact by you. If coverage is rescinded, Providence Health Assurance 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 a 30-day notice before rescinding your coverage.

Non-Liability After Termination

Upon termination of this Contract, 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 Assurance.

Notice of Creditable Coverage

We will provide, upon request, written certification of the Member's period of Creditable Coverage when:

- A Member ceases to be covered under this Contract; and
- A Member requests a Notice of Creditable Coverage within 24 months of the termination of coverage.

FURTHER CONDITIONS OF THIS CONTRACT

EFFECT OF CHANGE OF PLAN

If a Member switches to coverage under this Group Plan from any other Group Medicare Supplement Plan, no benefits will be paid under this Group Plan for any stay or care to the extent that benefits are paid under the prior Plan.

INDUCEMENTS NOT SPECIFIED IN CONTRACT

Except as otherwise expressly provided by the Insurance Code, no person shall permit, offer to make, or make any contract of insurance, or agreement as to such contract, unless all agreements or understandings by way of inducement are plainly expressed in the contract issued thereon.

RELEASING NECESSARY INFORMATION

Hospitals, Skilled Nursing Facilities, Physicians, Providers, Medicare intermediaries, other carriers, or other agencies often have information Providence Health Assurance needs to determine a Member's coverage or benefits. By enrolling for coverage in this Group Medicare Supplement Plan, Members authorize Providence Health Assurance to obtain such information. Providence Health Assurance will safeguard the confidentiality of these records.

CONFIDENTIALITY OF MEMBER INFORMATION

In accordance with the federal privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Providence Health Assurance will not disclose a Member's protected health information (PHI) to the Plan Sponsor or any agent of the Plan Sponsor unless requested and unless Providence Health Assurance determines that such disclosure is allowed.

- When a Member provides a written authorization that permits the Plan sponsor to access the Member's PHI as defined on the authorization form.
- When the information disclosed is the minimum necessary to allow the Plan Sponsor to know whether the Member is participating in the group health Plan or is enrolled or has disenrolled from the Plan.
- When summary health information is being requested for the purpose of obtaining premium bids from health Plans for providing health insurance coverage under the group health Plan or for the purposes of modifying, amending, or terminating the group health Plan.
- When the Plan Sponsor certifies that they have modified their Plan documents to allow access to PHI in compliance with 45 CFR 164.504 (f) (2).

Plan Sponsor agrees to limit further disclosures to those permitted by law, to ensure that any person with whom the PHI is disclosed makes similar agreements, not to use PHI for employment-related actions or decisions, not to use PHI for purposes related to any other benefits, to report to Providence Health Assurance any violations of these principles, to provide access to individuals to their PHI except as limited by law, to amend erroneous PHI as provided by law, to account for disclosures of PHI as provided by law, to be audited by the US Department of Health & Human Services as to its handling of PHI, to return all PHI to Providence Health Assurance when no longer required, and to separate employees not necessary to using the PHI from the functions for which the PHI is required.

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 Health Assurance's contract on Appointment of Authorized Member Representatives, and the form for doing so, may be accessed through our website at ProvidenceHealthPlan.com/forms.

The contract 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. At Providence Health Assurance, we respect the privacy and confidentiality of your protected health information (PHI). Providence Health Assurance takes great care to determine when it is appropriate to share your PHI, in accordance with federal and state privacy laws. We use PHI and may share it with others as part of your treatment, payment for your treatment, and our business operations.

The following are ways we may use or share information about you, consistent with law:

- We will use the information to administer your benefits and help pay your medical bills that have been submitted to us for payment.
- We may share your information with your doctors or Hospitals to help them provide medical care to you (e.g., if you are in the Hospital, we may give them access to any medical records sent to us by your doctor).
- We may use or share your information with others to help manage your health care (e.g., we might talk to your doctor to suggest a disease management or wellness program that could help improve your health).
- We may share your information with individuals who perform business functions for us. We will only share your information if there is a business need to do so and if our business partner agrees to protect the information.
- We may use your information to inform you about alternative medical treatments and programs or about health-related products and services that you may be interested in (e.g., we sometimes send out newsletters that let you know about "healthy living" alternatives such as smoking cessation or weight loss programs).
- We make every effort to release only the minimum amount of information necessary to meet any release requirement and only release information on a need-to-know basis. Also, wherever feasible, identifiable information is removed from any information shared.

To secure the confidentiality of medical information, we have procedures in place which you can review at www.ProvidenceHealthPlan.com/privacy.

When Member information is used in health studies, identifiable information is not released. All Member-specific information has identifying information removed, and aggregated data are used as early in the measurement process as possible. The privacy of our Members is completely protected.

Our agreements with Providers in our network contain confidentiality provisions that require Providers treat your PHI with the same care. Providers you may use who are outside of Providence Health Assurance's network are required to adhere to the same rules.

You have the right to ask us to restrict how we use or disclose your information for treatment, payment, or health care operations. You also have the right to ask us to restrict information we may give to persons involved in your care. While we may honor your request for restrictions, we are not required to agree to these restrictions. You also have the right to register a complaint if you believe your privacy is compromised in any manner.

Members may request to see their medical records. Call your Physician's or Provider's office to ask how to schedule a visit for this purpose.

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

MEMBER ID CARD

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

NON-TRANSFERABILITY OF BENEFITS

No person other than a Member is entitled to receive benefits under this Plan. Such right to benefits is non-transferable.

TIME LIMIT ON CERTAIN DEFENSES

After a Member's coverage under this Plan has been in effect for two years, Providence Health Assurance may not cancel, refuse to renew, or void a Member's coverage for a material misrepresentation or omission in the application, unless it was fraudulent.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on this contract prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this contract. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

No Member shall bring any action at law or in equity to recover benefits prior to receiving a final decision on an Appeal, as described in the Grievance and Appeal Rights section of this document. 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 Contract.

Further, no such action shall be brought later than three years after receiving a final decision on an Appeal.

PHYSICAL EXAMINATION AND AUTOPSY

Providence Health Assurance, at its own expense, shall have the right and opportunity to order an examination of any Member when and as often as Providence Health Assurance may reasonably require during the pendency of any claim covered by the Contract. Providence Health Assurance also has the right to order an autopsy in the case of death if not forbidden by law.

EXCLUSIONS

We will not pay for:

- Losses incurred while your contract is not in force
- Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this contract is not in force
- That portion of any loss incurred which is paid for by Medicare
- Services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take-home drugs, and eye refractions
- Services for which a charge is not normally made in the absence of insurance
- Losses payable under any other Medicare Supplement insurance contract or certificate
- Losses payable under any other insurance which paid benefits for the same loss on an expense incurred basis

PROOF OF LOSS

Written proof of loss must be furnished to the insurer at its office in case of claim for loss for which this contract provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

ELIGIBILITY DETAILS

"Eligible persons" is defined by employer group eligibility in addition to the following per State of Oregon regulations:

(a) An individual enrolled under an employee welfare benefit Plan, an individual health benefit plan, a state Medicaid plan as described in Title XIX of the Social Security Act or Tricare as described in Title XVIII of the Social Security Act that provides health benefits that supplement the benefits under Medicare and the plan terminates or ceases to provide all such supplemental health benefits; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the Plan terminates or ceases to provide all

health benefits to the individual.

(b) An individual enrolled with a Medicare Advantage organization under a Medicare Advantage Plan under Part C of Medicare, and any of the circumstances apply under OAR 836-052-0142(2)(b), or the individual is 65 years of age or older and is enrolled with a Program of All Inclusive Care for the Elderly (PACE) Provider under section 1894 of the Social Security Act, and there are circumstances similar to those described in this subsection that would permit discontinuance of the individual's enrollment with the Provider if the individual were enrolled in a Medicare Advantage Plan.

(c) An individual enrolled with an eligible organization defined in OAR 836-052-0142(2)(c)(A) and (B).

(d) An individual enrolled under a Medicare supplement contract and the enrollment cease due to circumstances described in OAR 836-052-0142(2)(d).

(e) An individual enrolled under a Medicare supplement contract and terminates enrollment and subsequently enrolls under circumstances prescribed in OAR 836-052-0142(2)(e)(A) and (B).

(f) An individual, within six months after becoming enrolled in Part B of Medicare, enrolls in a Medicare Advantage Plan under part C of Medicare, or with a PACE Provider under Section 1894 of the Social Security Act, and disenrolls from the Plan or program no later than 12 months after the effective date of enrollment.

(g) An individual enrolled in a Medicare Part D Plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement contract that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare Supplement contract and submits evidence in Medicare Part D along with the application for a contract described in OAR 836-052-0142(5)(d).

DEFINITIONS

The following are definitions of important terms used in this Certificate of Coverage and appear throughout this document.

Accident: An Injury sustained by a Member that is the direct result of an accident, independent of disease or bodily infirmity or any other cause and occurs while insurance coverage is in force.

Adverse Benefit Determination:

- 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 Experimental/Investigational or not Medically Necessary
- 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

Approved Amount: The amount Medicare determines to be reasonable for the service that is covered. It may be less than the actual charge. For many services, including Physician services, the Approved Amount is taken from a fee schedule that assigns a dollar value to all Medicare-covered services that are paid under that fee schedule.

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.

Assignment: An arrangement whereby a Physician, health care Provider, Hospital or Skilled Nursing Facility, or other medical supplier agrees to accept the Medicare Approved Amount as full payment for services and supplies covered under Part B and may not bill the Member for any more than the Medicare Deductible and Coinsurance. Medicare usually pays 80 percent of the Approved Amount directly to the Physician or supplier after the beneficiary meets the Deductible. The beneficiary pays the other 20 percent.

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

Benefit Period: The period used to measure a Medicare beneficiary's use of Hospital and Skilled Nursing Facility services covered by Medicare. A Benefit Period begins the day a Member is hospitalized. It ends after the Member has been out of the Hospital or other facility that primarily provides skilled nursing or rehabilitation services (or, if in the latter type of facility, has not received skilled care there) for 60 days in a row. If a Member is hospitalized after 60 days, a new Benefit Period begins, most Medicare Part A benefits are renewed, and the Member must pay a new inpatient Hospital Deductible. There is no limit to the number of Benefit Periods a Member can have.

Coinsurance: An amount a Member may be required to pay as a Member's share of the cost for a medical service or supply after Member pays any Deductible. Coinsurance is usually a percentage, for example, 20 percent.

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

Convalescent Nursing Home: A facility with medically trained staff who deliver short-term care. The people receiving convalescent care are getting temporary care to recover from some sort of set-back, such as an Injury, illness, or operation.

Copayment: An amount a Member may be required to pay as the Member's share of the cost for a medical service or supply, like a doctor's visit or Hospital outpatient visit. A Copayment is usually a set amount, rather than a percentage. For example, a Member might pay $10 or $20 for a doctor's visit.

Cost-Sharing: An amount a Member may be required to pay as a Member's share of the cost for a medical service or supply, like a doctor's visit or Hospital outpatient visit. This amount can include Copayments, Coinsurance, and/or Deductible.

Deductible: The amount a Member must pay for health care before Original Medicare or the Plan begins to pay.

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

Emergency Care: Care that is needed immediately for an Injury, illness, or condition of sudden or unexpected onset that would be deemed, under appropriate medical standards, to carry substantial risk of serious medical complication or permanent damage to a Member if care or services are withheld.

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; 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 Assurance.

Group Agreement: The document with that title which is part of the Group Contract, and which specifies the eligibility and coverage provisions under the Group Contract.

Group Contract: The provisions of the Plan Sponsor's document with that title, the Group Agreement, the Outline of Medicare Supplement Benefits for Group Sponsored Enrollees, the rate summary and any attached endorsements or amendments.

Group Participant: A person who participates in the Plan Sponsor's group and who is eligible to enroll in this Plan.

Guarantee Issue Rights (also called Medigap protections): Rights you have in certain situations when insurance companies must offer you certain Medigap policies. In these situations, an insurance company:

- Must sell you a Medigap contract
- Must cover all your pre-existing health conditions
- Cannot charge you more for a Medigap contract because of past or present health problems

In most cases, you have a Guaranteed Issue Right when you have other health coverage that changes in some way, like when you lose the other health care coverage. In other cases, you have a "trial right" to try a Medicare Advantage Plan (Part C) and still buy a Medigap contract if you change your mind.

Health Care Expenses: Expenses associated with the delivery of health care services to a Member.

Hospital: A Medicare-approved institution that provides care for which Medicare pays Hospital benefits.

Injury/Injuries: Bodily Injury caused by an Accident and resulting directly and independently of all other causes.

Lifetime Reserve Days: A lifetime reserve of 60 days for Medicare Part A inpatient Hospital care. These days must be used whenever more than 90 days of inpatient Hospital care are needed in a Benefit Period.

Limiting Charge: The maximum amount a Physician may charge a Medicare beneficiary for a covered Physician service if the Physician does not accept Assignment of Medicare claims. The limit is 15 percent above the fee schedule amount for non-participating Physicians. Limiting charge information appears on the Medicare Explanation of Medicare Benefits form or the Medicare Summary Notice (MSN).

Medicaid: A program of medical assistance for the poor and indigent, established under Title XIX of the Social Security Disability Act.

Medicare: Parts A and B of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Medicare Eligible Expenses: Expenses covered by Medicare, to the extent recognized asreasonable and medically necessary by Medicare.

Medicare Explanation of Benefits: The form Medicare sends to a Member to show whataction was taken on the Member's Medicare claim.

Medicare Part A Inpatient Hospital Deductible: The amount normally due from a Medicare beneficiary upon first admission to a Hospital in each Benefit Period, before benefits are available under Part A of Medicare.

Member: An individual who is eligible for and properly enrolled in this Plan and is entitled to services under the Contract.

Outline of Medicare Supplement Coverage for Group Sponsored Enrollees: Document summarizing the Plan benefits.

Participant: A person who participates who is eligible to enroll in this Plan.

Physician/Provider: A licensed practitioner of the healing arts acting within the scope of their license.

Plan: The benefits that are provided under the Group Contract.

Plan Sponsor: The employer of the Group Contract.

Providence Health Assurance: The nonprofit corporation authorized as a health care service contractor in the state of Oregon that issues the contract.

Psychiatric Care: The treatment for any neurosis, psychoneurosis, psychopathy, psychosis,mental or emotional disorder or disease, and alcoholism and drug addiction.

Sickness: Illness or disease of a Member that manifests itself after the Effective Date of Coverage under this Group Contract and while the coverage under this Group Contract is in force.

Skilled Nursing Facility: Facility that provides skilled nursing care and is approved forpayment by Group Medicare.

Subrogation: Providence Health Assurance may collect directly from the third party to the extent Providence Health Assurance has paid on the Member's behalf for third party liabilities.