PROVIDENCE
Health Assurance

# MEDICARE SUPPLEMENT POLICY

## FOR PROVIDENCE 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.**

### 30-DAY RIGHT TO EXAMINE YOUR POLICY

If you decide you do not want to purchase this policy for any reason, you may notify us within 30 days after delivery and your insurance will be deemed void from its effective date and premium payments received will be returned to you.

Any change in premium is subject to prior approval by the Oregon Department of Consumer and Business Services and will apply to all Members of the same age category insured under this Contract.

Medicare may, from time to time, change its Deductible and Copayment amounts. When this happens, we will automatically cover the charged amounts that are eligible for benefits. Benefits and cost vary depending upon the Plan selected. The policy coverage shall be guaranteed renewable but Providence Health Assurance reserves the right to change premiums and any renewal premium increases. On each annual anniversary of your Effective Date, premiums will increase due to the increase in your age. The renewal premium for this policy will be the renewal premium then in effect for your attained age. The premium may also change for other reasons. Any change in premium will apply to all covered persons in your same class based on the issue state of your policy. For any premium change under this paragraph, we will give you at least 30 days advance notice in writing of such premium change.

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

Mark Jensen, Chief Service Operations Officer Providence Health Assurance
4400 NE Halsey, Building 2, Suite 690
Portland, OR 97213

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## PROVIDENCE HEALTH ASSURANCE QUICK REFERENCE GUIDE

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|---|---|
| Customer Service Quick Reference Guide: General assistance with your Plan | 971-345-4013 (local)<br>888-231-9287 (toll-free)<br>711 (TTY)<br>ProvidenceHealthPlan.com |
| Providence Nurse Advice Line | 503-215-6755 (local)<br>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/Pubs/pdf/02110-medicare-medigap-guide.pdf |
| Customer Service:<br>Customer Service available Monday - Friday, 8 a.m. to 5 p.m. (Pacific Time) | 971-345-4013 (local)<br>888-231-9287 (toll-free) |
| Providence Health Assurance Medicare Supplement Application Form | ProvidenceMedicareSupplement.com |
| Providence Health Assurance Medicare Supplement Application Form mailing address | Providence Medicare Supplement<br>PO Box 14590<br>Salem, OR 97309 |
| Pay by mail | Monthly Premium Payment Options<br><br>Providence Medicare Supplement<br>PO Box 14590<br>Salem, OR 97309 |

## WELCOME TO PROVIDENCE HEALTH ASSURANCE

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

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

Important terms used in this Policy 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 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 - Friday between the hours of 8:00 AM to 5:00 PM (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 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 policy.
- Refuse care from specific providers.

Members have the responsibility to:

- Read and understand the information in and the terms of your 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 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 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 policy or decision that you believe prevents you from receiving appropriate care.
- Provide you with accurate 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 with access according to law.
- Ensure that your interests are well represented in decisions about Providence Health Assurance policy and governance.
- Encourage physicians and providers to make medical decisions that are always in your best interest.

## YOUR MEMBER ID CARD

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

- Your Member number; and
- 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 Medicare Supplement Contract.

When scheduling an appointment or receiving health services, identify yourself as a Providence 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 healthcare provider or facility
- Call or correspond with Customer Service
- Call Providence RN medical advice line
- Receive Immediate, Urgent or Emergency Care Services

## 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 flus, colds or backaches. After a brief recorded message, a registered nurse will come on-line to assist you.

Please have your Member ID Card available when you call.

## HEARING AID DISCOUNT

Members are eligible for discounts on over 200 hearing aid models from top hearing aid manufacturers through our partner TruHearing.

## HOUSEHOLD PREMIUM DISCOUNT

You may be eligible for a discount off your monthly premium if you are married or live with a domestic partner or adult at the same physical address.

## DISCLOSURES

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

- Some capitalized terms have special meanings in this contract. Please see Definitions section, starting on page 26.
- In this document, Providence Health Assurance is referred to as "we," "us" or "our." Members enrolled under this Contract are referred to as "you" or "your."
- In this document, your Medicare Supplement Contract is referred to as "Medicare Supplement" or "Supplement."
- If after examining this Contract you are not satisfied with it for any reason, you may cancel this policy within 30 days of receipt. Your decision to cancel this policy must be provided to us in writing within the 30-day period, and we will provide a full refund of your Premium and consider the policy void and never effective.
- Coverage under this Medicare Supplement Plan is available 24 hours a day, seven days a week and during periods of domestic or foreign travel*.
- Enrolled Policyholders must reside in our Service Area, which is all counties within the state of Oregon.
- The Contract for this Medicare Supplement Plan includes this document (Policy), 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) Medicare Supplement Policy, (3) Outline of Coverage, and (4) applicable Providence Health Assurance policies.

** Except in limited situations, Medicare does not pay for health care services you receive outside the U.S. However, Providence Medicare Supplement Plans G and N will cover emergency care outside the U.S. in certain circumstances. The plans pay 80 percent of the billed charges for certain medically necessary emergency care outside the U.S. after you meet the plan's deductible plus a $250 deductible for the year. These Medicare Supplement policies cover foreign travel emergency care if it begins during the first 60 days of your trip, and if Medicare does not otherwise cover the care, but would if the policyholder had been in the U.S.. Foreign travel emergency coverage with Medicare Supplement policies has a lifetime limit of $50,000. The intent of this benefit is not to provide robust coverage. Anyone planning on extensive traveling should research travel insurance. Remember, when traveling on a cruise ship, you are in a foreign country and it's important to note that cruise ships sail under foreign flags.*

## ELIGIBILITY

Eligibility for Medicare Supplement coverage is determined by the Centers for Medicare and Medicaid Services (CMS)-- the federal Agency who oversees Medicare. Currently, 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; and
- Permanently reside in the United States, and;
- Are currently domiciled in the state of Oregon.
- Individuals who become eligible for Medicare due to age, disability or end-stage renal disease on or after January 1, 2020

Members who do not maintain eligibility as specified above are not eligible for coverage under this Plan.

## ENROLLMENT AND DISENROLLMENT

All eligible Participants must enroll on enrollment forms or enrollment systems provided or approved by Providence Health Assurance. Application/enrollment information should be received by Providence Health Assurance at least 30 days prior to the requested Effective Date of Coverage. Providence Health Assurance cannot complete an enrollment unless:

- Providence Health Assurance receives a fully complete application/enrollment form that is signed and dated by the prospective enrollee; and
- The date of signature is prior to the requested effective date of coverage.

Members wishing to disenroll from this plan must submit a written disenrollment request to Providence. 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 & Payment section of this policy document.

## GENERAL EXCLUSIONS

This 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 TV's, 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 are 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 half-way 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 & PAYMENT

### 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
P.O. 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); or
- 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 https://healthplans.providence.org/members/understanding-plans-benefits/benefit-basics/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% 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 for any balance.

Upon exhaustion of the Medicare hospital inpatient coverage including the Lifetime Reserve Days, coverage of 100% 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 policy will be paid immediately upon receipt of due written proof of loss. Losses for which this policy provides periodic payment will be paid (insert period for payment, which must not be less frequently than monthly).

**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.)**

## THIRD PARTY LIABILITY/SUBROGATION

Once it has been established that a third party is responsible to pay and is capable of paying for a member's medical expenses, Providence Health Assurance will not provide benefits for the services arising from the condition caused by that third party.

If Providence Health Assurance makes claim payments on a member's behalf for which a third party is responsible, Providence Health Assurance is entitled to be repaid for those payments out of any recovery that the member obtains from the third party. Providence Health Assurance will request reimbursement from the member to the extent that the third party does not pay Providence Health Assurance directly. Providence Health Assurance may also request refunds from the medical Providers who treated the member. In those cases, the involved Providers may bill the member or the third party for their services.

## 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 so we may help you with whatever 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.

<u>Filing a Grievance</u>

Members should file a grievance within 180 days of the occurrence that led to the grievance and should include all of 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, or for hearing impaired users, at 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 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
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)

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 the Internet at healthcare.oregon.gov/shiba/.

For grievances that involve Medicare coverage itself, members should call Medicare directly at 1-800-Medicare (1-800-633-4227).

## MOVING OUT OF THE SERVICE AREA

If you move out of the Service Area (defined as the State of Oregon), you must immediately notify us since such a move may affect your benefits or coverage under this Plan. We will determine how this move affects your coverage and will inform you of any changes.

## SUSPENSION OF MEMBER COVERAGE

If you become eligible for Medicaid after purchasing this policy, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility.

## TERMINATION OF MEMBER COVERAGE

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

1. The date the Contract terminates;
2. The end of the period for which required premium was due to Providence Health Assurance and is not received by Providence Health Assurance;
3. The last day of the month in which a member does not maintain his/her enrollment under both Parts A and B of Medicare;
4. The date stated when an individual no longer qualifies as an eligible individual;
5. The date stated, if applicable, when a member is no longer in an eligible class of persons;
6. The end of the month in which a member requests termination of his/her coverage to be effective;
7. The date on which any fraudulent information is provided by a member that affects his/her eligibility or benefits under this Contract; or
8. The date on which Providence Health Assurance discover any breach of contractual duties, conditions or warranties by a member, as determined by Providence Health Assurance.
9. The last day of the month in which the enrolled Member ceases to reside in our

Service Area

10. For a deceased Member, after documentation has been submitted, the date of death

Termination of a Medicare supplement policy shall be without prejudice to any continuous loss which commenced while the policy was in force.

After two years from the date of policy issue, no misstatements except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or deny a claim.

This policy shall provide the opportunity for suspension at the request of the policyholder or certificate holder for a period not to exceed 24 months.

Beginning on a person's birthday, and for 30 days after, a Medicare supplement policy owner may cancel their existing Medicare supplement policy or certificate and purchase another Medicare supplement policy or certificate with the same or lesser benefits to replace the existing policy or certificate.

## PREMIUMS, RENEWAL, REVISION, RESCISSION, AND REINSTATEMENT

**PREMIUMS**

Premium Billing Information

Providence Health Assurance will provide a Premium billing statement on a monthly basis to the Policyholder listing the amount of Premium due.

Changes in Premium Charges

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

1. The Premium is subject to change upon renewal of this Contract for another Plan Year.
2. 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 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

The Premium is due on the first of the month. If the Policyholder does not pay the Premium by the first of the month, the policy will be in a 60 day grace period (two billing cycles). We will mail two Premium delinquency notices to the Policyholder. If the Policyholder does not pay the Premium by the last day of the 60 day grace period, as specified in the notice, coverage will be terminated retroactively to the month you last paid in full, with no further notice to the Policyholder. Failure to pay the Premium includes making a partial payment of the amount due as Premium. If we fail to send the Premium delinquency notice specified above, we will continue the Contract in effect, without payment of Premium, until we provide such notice.

**RENEWAL AND REVISION**

This 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 Medicare Supplement plan, it renews every year as long as you pay your premium and the plan is available.

We may revise this Contract upon renewal with prior approval from the Oregon Insurance Division and written notice to you at least 30 days prior to the start of a new Plan Year.

Your payment of premium constitutes acceptance of any revisions to the provisions of this Contract that may occur at renewal or outside of renewal as permissible by applicable federal or state law.

The receipt of Medicare Part D benefits will not be considered in determining a continuous loss. Per CMS regulations, Medicare Supplement policies can no longer be sold with prescription drug coverage, but if you have drug coverage under a current Supplement policy, you can keep it. If you join a Medicare drug plan, Providence Health Assurance must remove the prescription drug coverage under your Medigap policy and adjust your premiums.

**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:

- You have filed false claims with us;
- You have allowed a non-Member to use your Member ID card to obtain Services; or
- You provided 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.

**REINSTATEMENT**

If the renewal premium has not been paid within the time granted and Providence or an authorized agent accepts a subsequent premium, Providence shall reinstate the policy.

## FURTHER CONDITIONS OF THIS CONTRACT

**EFFECT OF CHANGE OF PLAN**

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

**NOTICE OF PRIOR COVERAGE**

Providence Health Assurance will provide written certification of a member's period of creditable coverage when the member ceases to be covered under this Plan or when a member requests a Notice of Creditable Coverage within 24 months after his/her coverage ceases under this Plan.

**INDUCEMENTS NOT SPECIFIED IN POLICY**

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 policy 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 Medicare Supplement Plan, members authorize Providence Health Assurance to obtain such information. Providence Health Assurance will safeguard the confidentiality of these records.

**PRIVACY OF MEMBER INFORMATION**

At Providence Health Assurance, 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 Assurance 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 copies of their medical records from the 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 https://healthplans.providence.org/members/rights-notices/ 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 https://healthplans.providence.org/members/understanding-plans-benefits/benefit- basics/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. 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 protected health information and may share it with others as part of your treatment, payment for your treatment, and our business operations.

The following are ways we may use or share information about you, 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 provide you with information 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 personal health information with the same care. Providers you may use who are outside of the Providence 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.

**FAILURE TO PROVIDE INFORMATION OR PROVIDING INCORRECT OR INCOMPLETE INFORMATION**

Members warrant that all information contained in applications, questionnaires, forms, or statements submitted to us to be true, correct, and complete. If a member willfully fails to provide information required to be provided or knowingly provides incorrect or incomplete information, then plan coverage for the affected member(s) may be terminated as described in the "Termination of Member Coverage" section.

**MEMBERSHIP ID CARD**

The membership 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 his/her application, unless it was fraudulent.

**LEGAL ACTIONS**

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. 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.

**PRE-EXISTING CONDITION LIMITATIONS**

This policy does not pay benefits for Loss which occurs within six months after the Effective Date as a result of a pre-existing condition. A pre-existing condition is any injury, Sickness or disease for which the insured has received, or has had recommended, medical advice or treatment during the six months before the Effective Date of Coverage. Please note that pre-existing conditions will be covered after six months from the Effective Date. This exclusion does not apply to Loss which occurs more than six months after the Effective Date.

If you apply for this policy during the 6 month period beginning with the first day of the first month in which you are eligible and as of the date you apply, you had a Continuous Period of Creditable Coverage of at least 6 months the pre-existing conditions limitation will not apply to you.

If you apply for this policy during the 6 month period beginning with the first day of the first month in which you eligible, and as of the date you apply you had a Continuous Period of Creditable Coverage of less than 6 months, the pre-existing conditions limitation will be reduced by the aggregate of the period of Creditable Coverage applicable as of your enrollment date.

If this policy is issued to replace another Medicare supplement policy or as a result of certain situations involving health coverage changes, the pre-existing conditions exclusion will not be applied. Some of these situations include: loss of your policyholder's group coverage; termination of a Medicare Advantage Plan, including termination of coverage because you moved out of the plan's service area or the insurance company that provided you Medicare Supplement coverage went out of business or committed fraud.

**EXCLUSIONS**

We will not pay for:

1. Losses incurred while your policy is not in force;
2. Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force;
3. That portion of any loss incurred which is paid for by Medicare;
4. Services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take-home drugs and eye refractions;
5. Services for which a charge is not normally made in the absence of insurance;
6. Losses payable under any other Medicare supplement insurance policy or certificate; or
7. 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 policy 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 as one of the following per State of Oregon regulations:

(a) An individual enrolled under an employee welfare benefit plan that: (1) supplements the benefits under Medicare and the plan terminates or ceases to provide all supplemental health benefits; or (2) is primary to Medicare and the plan terminates or ceases to provide all health benefits.

(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 policy and the enrollment ceases due to circumstances described in OAR 836-052-0142(2)(d).

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

and (B).

(f) An individual, upon first becoming enrolled for benefits under Medicare part A, 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 policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare Supplement policy and submits evidence in Medicare Part D along with the application for a policy 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** means an accidental injury sustained by a Member this 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.

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 Experimental/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.

**Approved Amount** means 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** means 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** means 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% of the approved amount directly to the Physician or supplier after the beneficiary meets her or his Deductible. The beneficiary pays the other 20%.

**Authorized Representative** means an individual who by law or by the authorization of a Member may act on behalf of the Member.

**Benefit Period** means 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** means 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%.

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

**Convalescent Nursing Home** means 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** means an amount a Member may be required to pay as 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** means 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** means the amount a Member must pay for health care before Original Medicare or the Plan begins to pay.

**Effective Date of Coverage** means the date upon which coverage under the Contract commences for a member.

**Emergency Care** means 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** means 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 Assurance.

**Guarantee Issue Rights** (also called "Medigap protections") are 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 policy
- Must cover all your pre-existing health conditions
- Can't charge you more for a Medigap policy 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 policy if you change your mind.

**Health Care Expenses** means expenses associated with the delivery of health care services to a Member.

**Hospital** means a Medicare-approved institution that provides care for which Medicare pays hospital benefits.

**Injury** or **Injuries** means bodily Injury caused by an Accident and resulting directly and independently of all other causes.

**Lifetime Reserve Days** means 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** means 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 Explanation of Medicare Benefits (EOMB) form or the Medicare Summary Notice (MSN).

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

**Medicare** means 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** means expenses covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

**Medicare Explanation of Benefits** means the form Medicare sends to a member to show what action was taken on member’s Medicare claim.

**Medicare Part A Inpatient Hospital Deductible** means 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** means 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** means the document with that title which summarizes the Plan benefits.

**Participant** means a person who participates who is eligible to enroll in this Plan.

**Physician/Provider** means a licensed practitioner of the healing arts acting within the scope of his/her license.

**Plan** means the benefits that are provided under the Contract.

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

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

**Sickness** means illness or disease of a Member that manifests itself after the effective date of coverage under this Contract and while the coverage under this Contract is in force.

**Skilled Nursing Facility** means a facility that provides skilled nursing care and is approved for payment by Medicare.

**Subrogation** means that 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.