pebb
Public Employees' Benefit Board

2026 Member Handbook

Group # 106528

Providence Choice

Administered by Providence Health Plan
P.O. Box 4327
Portland, Oregon 97208-4327
Telephone: 503-574-7500
Toll-free: 800-878-4445
TTY: 711

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1. INTRODUCTION

TO: PEBB Members

FROM: Public Employees' Benefit Board (PEBB)

Thank you for choosing the Providence Choice Plan. We look forward to meeting your health care needs. The following is a brief outline of several key aspects of Providence Choice.

The benefits described on the following pages are effective Jan. 1, 2026, and were designed to provide you and your dependents as PEBB Members with the best possible medical care at competitive rates. PEBB has designed this Plan in cooperation with Providence Health Plan. The benefits under the Plan are provided by PEBB on a self-insured basis. Because this Plan is self-insured, it is subject to PEBB's funding limitations, including but not limited to legislative appropriations, PEBB fund balances, and the limits imposed by laws that apply to PEBB. PEBB has contracted with Providence Health Plan to process claims and provide customer service to Participants. However, Providence Health Plan does not insure or otherwise guarantee any benefits under the Plan.

This Member Handbook contains important information about the health plan coverage offered to PEBB members. It is important to read this Member Handbook carefully as it explains your benefits and member responsibilities. If you do not understand a term that is used, you may find it in Definitions, section 14. Should you require additional information concerning this medical Plan or any other topic related to your medical insurance, please contact the plan administrator at the numbers listed below.

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

- Some capitalized terms have special meanings. Please see section 14, Definitions.
- In this handbook, Members participating in the Providence Choice Plan are referred to as "you" or "your".
- Members must choose a Medical Home as soon as possible. If you do not select a Medical Home within 30 days of your coverage beginning, you will be assigned one in your area.
- All Members are encouraged to choose a Medical Home Primary Care Provider who will provide preventive and primary care Services and coordinate other care in a convenient and cost-effective manner.
- Providence Choice is a Medical Home Plan. With Providence Choice, Members will have lower out-of-pocket expenses when obtaining Covered Services from your Medical Home provider or when your care is coordinated by your Medical Home provider. Members may obtain most Covered Services from non-Medical Home providers, but that will result in higher out-of-pocket expenses for most Covered Services. Please see section 3 and your Benefit Summary for additional information.
- A printable directory of Medical Homes in the Providence Choice Network is available at join.collectivehealth.com/PEBB-php.

- **Certain Covered Services require an approved Prior Authorization, as specified in section 4.4.**
- If there are no In-Network providers in your area, or if you require unique Medically Necessary skills or Services that are not available from any In-Network providers in your area, you may request a Prior Authorization to be seen by an Out-of-Network provider or facility at the cost of your In-Network benefit. Allowable charges are based on Usual, Customary, and Reasonable (UCR) rates. These Services may be subject to review for Medical Necessity.
- Coverage under the Providence Choice Plan is available 24 hours a day, seven days a week and during periods of domestic and foreign travel.
- All Covered Services are subject to the provisions, limitations and exclusions that are specified in the Providence Choice Plan. You should read the provisions, limitations, and exclusions before seeking services, because not all health care services are covered by this Plan.

Customer Service Quick Reference Guide:

Medical, Mental Health, Substance Use Disorder, and prescription drug claims a benefits	855-284-1368 711 (TTY) Join.collectivehealth.com/PEBBphp
Mail order prescription drug services	Join.collectivehealth.com/PEBBphp
Medical, Mental Health, and Substance Use Disorder Prior Authorization Requests	855-284-1368(toll-free)
Virtual Care and Nurse Advice Line - Galileo	855-462-7943 www.galileo.health/providence
Providence Resource Line for health education classes	503-574-6595 (local/Portland area) 800-562-8964 (toll-free)
My Collective Help Desk	(855) 284-1368
Provider Directory	join.collectivehealth.com/PEBB-php

2. WELCOME TO PROVIDENCE HEALTH PLAN

Thank you for choosing Providence Health Plan. We look forward to meeting your health care needs. Providence Health Plan is an Oregon licensed Health Care Services Contractor whose parent company is Providence Health & Services. Our goal is to help improve the health status of individuals in the communities in which we serve. This booklet contains important information about the PEBB Providence Choice Health Plan coverage offered to PEBB Subscribers and their Dependents.

2.1 YOUR PROVIDENCE CHOICE PLAN

Your Providence Choice Plan allows you to receive Covered Services from your Medical Home through what is called your In-Network benefit. Your plan also provides coverage for Services from other In-Network and Out-of-Network Providers. See sections 3.1–3.3 for details about Medical Homes. A woman may choose to access an In-Network Women's Health Care Provider not in her Medical Home.

You also have the option to receive Covered Services from Out-of-Network Providers through what is called your Out-of-Network benefit.

Generally, your out-of-pocket costs will be less when you receive Covered Services from your Medical Home Provider and when your care is coordinated through your Medical Home.

How to Choose a Medical Home

Start by selecting a Medical Home. There are many Medical Homes to choose from. You and your covered Dependents may choose the same or different Medical Homes, depending on your preferences and needs. If you do not select a Medical Home within 30 days of your coverage beginning, you will be assigned one in your area.

Once you have chosen a Medical Home, you must communicate your Medical Home selection to Providence Health Plan before receiving services:

- **Online**: Visit My Collective to log into your account and select a Medical Home for you or your family*
- **Phone:** Call Collective Health Member Advocates at 855-284-1368

  Member Advocate Support:
  Monday-Friday: 4:00 a.m. to 6:00 p.m. PT
  Saturday: 7:00 a.m. to 11:00 a.m. PT
  Sunday: Closed
  Support Channel Type: Client Specific Phone Number, Chat

  *Adults age 18 and over must log into My Collective separately to select their own Medical Home.

If you decide to change your Medical Home selection for yourself or any of your Enrolled Family Members during the Plan year, you must communicate the change to Providence Health Plan before seeking Services from the new Medical Home. You can notify us of the change using any of the notification methods listed above.

Your Medical Home Provider is available to answer your health-related questions 24 hours a day, seven days a week.

Your Medical Home Provider will work with us to Prior Authorize treatment. If you receive Covered Services from Out-of-Network Providers, it is your responsibility to make sure the Services are Prior Authorized by Providence Health Plan before treatment is received.

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

If you are unsure about a physician/provider's, Hospital's, or other facility's participation with Providence Health Plan, visit our Online Network Provider Directory at join.collectivehealth.com/PEBB-php before you make an appointment. Select "PEBB Providence Choice Medical Home" from the *Search by specific plan* drop down menu. If you are searching for a Medical Home, be sure to confirm that the provider you have selected is a Medical Home, is accepting new patients, and accepts your Providence Choice Plan.

Whenever you visit a Providence Choice Provider:

- Bring your Providence Health Plan Powered by Collective Health identification card with you.
- If your office visit is subject to a Copayment, you will need to make that Copayment at the time of your visit.
- If your office visit is subject to a Coinsurance (a percentage of the amount billed for Services), you will most likely not be asked to pay for what you owe at the time of your visit. Your provider's office will send you a bill for what you owe later. Some providers, however, may ask you to pay for an estimate of what you may owe at the time you receive Services and bill or credit you for the balance later.

2.2 MEMBER HANDBOOK

This Member Handbook contains important information about the health plan coverage offered to PEBB Members. It is important to read this Member Handbook carefully as it explains your Plan benefits and Member responsibilities. If you do not understand a term that is used, you may find it in Definitions, section 14. If you need additional help understanding anything in this Member Handbook, please call Collective Health Member Advocates at (855) 284-1368. *See section 2.3 for additional information on how to reach Customer Service.*

This Member Handbook is not complete without your:

- **PEBB Providence Choice Benefit Summary**. These materials are available when you register for a My Collective account as explained in section 2.4. Benefit Summaries detail your Deductibles, Copayments and Coinsurance for Covered Services.
- **Provider Directory,** which lists In-Network Providers and is available online at join.collectivehealth.com/PEBB-php. If you do not have Internet access, please call Collective Health Member Advocates (855) 284-1368.

If you need more detailed information for a specific problem or situation, contact Collective Health Member Advocates (855) 284-1368.

2.3 CUSTOMER SERVICE

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

- Specific benefit or claim questions.
- Questions or concerns about your health care or Service.

Contacting Collective Health Member Advocates
Please have your Member ID Card available when you call:

- Members please call toll-free: (855) 284-1368.
- Members with hearing impairment, please call the TTY line: 711.

Member Advocate Support:
Monday-Friday: 4:00 a.m. to 6:00 p.m. PT
Saturday: 7:00 a.m. to 11:00 a.m. PT
Sunday: Closed
Support Channel Type: Client Specific Phone Number, Chat

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

2.4 YOUR EMPLOYER'S HUMAN RESOURCES

For enrollment issues, questions or concerns about adding or dropping a Dependent, or to report name and address changes, please contact the human resource department located at your work place.

2.5 REGISTERING FOR A MY COLLECTIVE ACCOUNT

Providence Health Plan Members can create a My Collective account online at join.collectivehealth.com/PEBB-php. A My Collective account enables you to view your personal health plan information (including your Member Handbook, Benefit Summary, and a PDF copy of your Member ID card), view claims history and benefit payment information, order a replacement Providence Health Plan Powered by Collective Health ID Card, and access other health and wellness tools and Services.

- For technical issues related to your My Collective account, help desk representatives are available to assist you.

Member Advocate Support:
Monday-Friday: 4:00 a.m. to 6:00 p.m. PT
Saturday: 7:00 a.m. to 11:00 a.m. PT
Sunday: Closed
Support Channel Type: Client Specific Phone Number, Chat

2.6 YOUR PROVIDENCE HEALTH PLAN POWERED BY COLLECTIVE HEALTH ID CARD

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

- Your Plan identification number and group number
- Important phone numbers

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

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

Please keep your Providence Health Plan Powered by Collective Health ID Card with you and use it when you:

- Register for your My Collective account.
- Visit your health care provider or facility.
- Contact Mental Health/Substance Use Disorder Member Advocates.
- Contact or correspond with Member Advocates.
- Contact Collective Health Care Navigation
- Contact Galileo for virtual care and nurse advice line.
- Visit your pharmacy for prescriptions.
- Receive Immediate, Urgent or Emergency Care Services.
- Call Weight Watchers® to access your weight management benefits.

2.8 WELLNESS BENEFITS

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

- Providence Health Resource Line
  - Information on services, classes, self-help, smoking cessation and other services.
  - You can access by calling 503-216-7969 or 800-562-8964 or visiting https://healthplans.providence.org/members/member-groups/pebb/wellness-resources/.
- Health education classes
  - Providence Health Plan Members may receive discounts on health education classes supporting smoking cessation, childbirth education and weight management.
  - You can access by calling the Providence Resource Line at 800-562-8964 or visiting www.providence.org/classes.
- Collective Health Care Navigation
  - Access to highly skilled care teams who provide personalized education, health care navigation, and can help you coordinate care for your health conditions, including asthma, cancer, diabetes, Mental Health, and more. Care Management Services are available for all Members at no cost.

    - Members can receive free coaching support for weight loss, diabetes prevention, nutrition, stress management, exercise, sleep and tobacco cessation.
    - Ready to get started? Call (855) 284-1368.
- Wellness information
    - You can find medical information, class information, information on extra values such as online tools and discounts and other information by visiting www.providence.org/healthplans.
- LifeBalance Program
    - Discounts on health, wellness, recreational and cultural activities.
    - You can access your LifeBalance program by calling 503-234-1375 or 888-754-LIFE or visiting www.LifeBalanceProgram.com.
- Travel Assistance Services
    - Emergency logistical support to Members traveling internationally or people traveling 100 miles from home.
    - Contact by calling 609-986-1234 or 800-872-1414 or visit www.assistamerica.com.
- Identity Theft Protection
    - Identity theft protection program for Providence Health Plan Members.
    - Please call 614-823-5227 or 877-409-9597 or visit www.assistamerica.com/Identity-Protection/Login to sign up for the program; you will need your Health Plan Member ID number, and tell them your code is 01-AA-PRV-01193.

Garner Health Technology Provider Search Tool

Providence Health Plan is partnering with Garner, a tool that helps you find high-quality care. When you choose to visit a Garner-approved Top Provider, you may be repaid **up to the annual limit** for the costs you pay for your visit. This includes your deductible, copay, or coinsurance. It also includes other services like labs, prescriptions, and X-rays when they are ordered by your Top Provider.

You may be repaid up to:

- $1,000 of your cost share per year, if you have individual coverage.
- $2,000 of your cost share per year, if you have family coverage.

Garner is especially useful when looking for a specialist or a new provider.

To get started finding a Top Provider:

- Go to app.getgarner.com
- Use the Garner Health app
- Call 458-488-4828

Have an FSA? Keep in mind that if you have an FSA, you can't be reimbursed for the cost of your visit by both Garner and your FSA. It would violate IRS rules about tax-advantaged plans.

This program is not health insurance. Providence Health Plan is not affiliated with Garner and does not aid in data collection or provider scoring. Providence Health Plan is not responsible for any reimbursement from utilizing Garner to see Garner Top Providers and does not administer HRAs.

2.9 PRIVACY OF MEMBER INFORMATION

Providence Health Plan respects your privacy rights. This includes limiting who can access your personal data and how it is used. Your personal data includes information about your race, ethnicity, language, sexual orientation, and gender identity.

Providence Health Plan does not use your personal data for:

- Decisions about eligibility, benefits, coverage, or policy, except in situations that benefit you
- Decisions about the cost of services

Providence Health Plan may use your personal data for:

- Understanding your individual needs and the needs of the community
- Programs intended to improve your health and health care
- Sharing your language preferences with your care team
- Required reports to regulatory or compliance organizations

Protected Health Information (PHI)

At Providence Health Plan, we respect the privacy and confidentiality of your protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA). PHI refers to information about your health or health care Services that can be used to identify you as an individual. This includes:

- Details about your past, present, or future physical or Mental Health or condition
- Information related to the provision of health care to you
- Payment information related to your health care Services

In addition to PHI, we also protect your Personally Identifiable Information (PII), which includes data that can be used to identify you individually such as your name, address, date of birth, or Social Security number. We understand the sensitivity of this information and have policies in place to safeguard it from unauthorized access, use, or disclosure. We collect PII as part of our business operations to verify identity, manage member accounts, and support the delivery of health plan Services. Protecting your PII is an essential part of earning and maintaining your trust as a valued member.

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

For more information about uses and disclosures of Member information, including uses and disclosures required by law, please refer to our Notice of Privacy Practices. A copy is available at ProvidenceHealthPlan.com/nopp or by calling Member Advocates at (855) 284-1368.

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, contact Collective Health for appointment of authorized representative. The form must be signed by both the Member and the Authorized Representative. 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 represents a medical service provider whose services are a part of the claim in issue.

Confidentiality and your Employer

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

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

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

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

3. ELIGIBILITY AND ENROLLMENT

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

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

3.1 PEBB MEMBER ELIGIBILITY AND ENROLLMENT

3.1.1 Eligibility, Effective Date, Enrollment

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

3.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

3.2.1 Eligible Family Dependents, Eligibility Date

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

3.2.2 Eligible Family Dependent Enrollment

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

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

A newborn, newly adopted child, or newly fostered child of a Participant who meets the definition of a PEBB Eligible dependent child is eligible for enrollment from the date of birth or placement for the purpose of adoption or foster care. The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the PEBB eligibility rules and the PEBB Summary Plan Description for detailed information on eligibility and program requirements.

3.3 SPECIAL ENROLLMENT PERIODS

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

3.3.1 Premium Assistance

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

3.3.2 Position Change

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

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

4. HOW TO USE YOUR PLAN

Our goal is maintaining your health by promoting wellness and preventive care. We encourage you to work closely with one provider, your Medical Home provider, who can provide most of your care and coordinate Hospital care or diagnostic testing.

Coverage under this Plan is provided through:

- The Providence Choice Network of Network Medical Home clinics located in **Baker, Benton, Clackamas, Clark (WA), Clatsop, Coos, Crook, Curry, Deschutes, Douglas, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Payette (ID), Polk, Tillamook, Umatilla, Union, Walla Walla (WA), Wallowa, Wasco, Washington, Wheeler, and Yamhill counties** (the Service Area for this Plan);
- A national network of In-Network Providers, which allows Members to take advantage of contracted fees when accessing care outside the Medical Home; **plus**
- Out-of-Network Providers.

With the design of this Plan, you will have lower out-of-pocket expenses when you obtain Covered Services from the Medical Home Provider you selected and recorded with Providence Health Plan, or are referred by your Medical Home Provider to a Providence Choice In-Network Provider. You may, however, obtain Covered Services from an Out-of-Network Provider, but that option will result in higher out-of-pocket expenses for most Covered Services. Please see the Benefit Summary and section 3.2 for additional information.

You are encouraged to choose a Medical Home Provider who will provide preventive and primary care Services and coordinate other care in a convenient and cost-effective manner (see section 4.1).

Certain Covered Services require Prior Authorization, as specified in section 4.4.

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

4.1 MEDICAL HOMES

Medical Homes have a special agreement with Providence Health Plan to provide and manage your health care. This means that not all In-Network Providers and Facilities are Medical Homes. Please refer to the Provider Directory for a listing of designated Medical Homes. The Provider Directory can be found at our website at join.collectivehealth.com/PEBB-php. If you do not have access to our website, please call Collective Health Member Advocates to request In-Network Provider information.

Advantages of Using a Medical Home

- In most cases, when you use your Medical Home higher benefit levels apply and your out-of-pocket expenses will be reduced.
- Your Medical Home will coordinate care, when necessary, with a wide variety of high-quality specialists to help meet your health care needs.
- Your Medical Home will coordinate preventive health screenings and test results, ensuring your entire care team has the information they need to support your treatment plan.

So remember, it is to your advantage to meet your health care needs by using your Medical Home whenever possible.

4.1.2 Indian Health Services Providers

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

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

4.2 THE ROLE OF A MEDICAL HOME PRIMARY CARE PROVIDER

To encourage optimum health, we promote wellness and preventive care. We also believe wellness and overall health is enhanced by working closely with one physician or provider – your Medical Home Primary Care Provider. Your Medical Home Primary Care Provider can provide most of your care and, when necessary, will coordinate care with other providers in a convenient and cost-effective manner.

4.2.1 Medical Home Primary Care Providers

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

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

IMPORTANT NOTE: Medical Home Providers have a special agreement with Providence Health Plan to serve as case manager for your care. This means not all of the Medical Home Providers with the specialties listed above are Medical Home Primary Care Providers. Please refer to the Provider Directory, available online, for a listing of designated Medical Home

Primary Care Providers or call Collective Health Member Advocates at (855) 284-1368 to request a hard copy.

4.2.2 Established Patients with Primary Care Providers

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

4.2.3 Changing Your Medical Home Primary Care Provider

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

4.2.4 Office Visits

Medical Home Primary Care Providers

We recommend you see your Medical Home Primary Care Provider for all routine care and call your Medical Home Primary Care Provider first for urgent or specialty care. If you need medical care when your Primary Care Provider is not available, another provider within your Medical Home may treat you and/or refer you to another In-Network Provider for treatment.

Specialists

Your Medical Home Primary Care Provider will discuss with you the need for diagnostic tests or other specialist Services; and may also refer you to an In-Network specialist for your condition. Your Medical Home will coordinate your care with any Prior Authorization needed.

Whenever you visit a specialist:

- Bring your Providence Health Plan Powered by Collective Health Member ID Card.
- Understand that in most cases, your out-of-pocket costs will be a percent of the charges for Services. Your provider's office will send you a bill for the amount you owe. Some providers, however, may ask you to pay an estimate of what you may owe at the time you receive Services, and will bill or credit you the balance later.

Alternative Care Providers

Your Providence Choice Plan includes coverage for office visits to Alternative Care Providers, as listed in your Benefit Summary. See section 14 for the definition of Alternative Care Provider. For coverage of chiropractic manipulation and acupuncture, see sections 5.10.15, 5.10.16 and your Benefit Summary.

4.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS

As a Medical Home Member, you may choose to receive Covered Services from an Out-of-Network Qualified Practitioner or facility using your Out-of-Network benefit. See section 4.4 for Prior Authorization requirements.

Benefits for Covered Services received from an Out-of-Network Provider will be provided shown in the Benefit Summary.

Generally, when you receive Services from an Out-of-Network Provider, your Copayments and Coinsurance will be higher than when you see your Medical Home Provider to see an In-Network Provider.

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

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

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

Some Services are available only under your In-Network benefits:

- Retail Health Clinic Visits (see section 5.1.7);
- Bariatric Surgery and related Services (see section 5.10.2).
- Tobacco Use Cessation Services (see section 5.2.12).
- Water births (see section 5.3);
- Prescription Drugs (see section 5.11).
- Human Organ/Tissue Transplants (see section 6.1).
- Temporomandibular Joint (TMJ) Services (see section 6.2.1).
- Any item listed in your Benefit Summary as "Not Covered" under Out-of-Network.

Prescription Drugs Benefit, you must be purchased at one of our nationwide Participating Pharmacies (see section 5.11). A list of our Participating Pharmacies is available online at my.collectivehealth.com. You also may contact Collective Health Member Advocates at (855) 284-1368 if you need help locating a Participating Pharmacy near you or when you are away from your home. See your Benefit Summary for details on your Deductible, Copayment and Coinsurance, if applicable, and on how to use this benefit.

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

After you meet your Deductible, if applicable, and if the Services provided are Medically Necessary Covered Services, we will provide payment to Out-of-Network Providers according to Usual, Customary, and Reasonable charges (UCR). UCR charges do not include sales

taxes, handling fees and similar surcharges; such taxes, fees and surcharges are not covered expenses. See section 14 for the definition of UCR.

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

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

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

Payment for Out-of-Network Provider Services with Network Access Exception
If there are no In-Network providers in your area, or if you require unique Medically Necessary skills or Services that are not available from any In-Network providers in your area, you may request a Network Gap Exception to be seen by an Out-of-Network provider or facility at the cost of your In-Network benefit. Allowable charges are based on UCR rates. These Services may be subject to review for Medical Necessity.

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

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

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

4.4 COVERED SERVICES THAT REQUIRE PRIOR AUTHORIZATION

While Prior Authorization is a requirement for coverage of certain Services under this Plan, Prior Authorization is not a treatment directive. The actual course of medical treatment that a Member chooses remains strictly a matter between the Member and the Member's physician and is separate from the Prior Authorization requirements of this Plan. Prior Authorization is not a guarantee of benefit payment under this Plan and a Prior Authorization

determination does not supersede other specific provisions of this Plan regarding coverage, limitations, exclusions and Medical Necessity.

Services received from Medical Homes or Specialists:
Some Services from a Medical Home or Specialist need Prior Authorization. The provider must obtain this from Collective Health. This is true for Services completed from an In-Network Provider.

Services received from Out-of-Network Providers:
When Services are received from an Out-of-Network Provider, the Member is responsible for obtaining Prior Authorization. You or your provider must contact Collective Health to obtain Prior Authorization.

Services requiring Prior Authorization:
A comprehensive list of services and supplies that must be Prior Authorized is available by visiting our website at join.collectivehealth.com/PEBB-php. You may also contact Collective Health Member Advocates at (855) 284-1368 to inquire whether a service or supply requires Prior Authorization. You or your Provider should submit Prior Authorization requests by following the instructions on our website. We will not require Prior Authorization for services and supplies that by law do not require Prior Authorization, including Emergency Room services.

Providence Health Plan will provide a Prior Authorization form upon oral or written request. If you need information on how to obtain Prior Authorization, please call Collective Health Member Advocates at (855) 284-1368.

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

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

You or the Out-of-Network Provider should call Collective Health at (855) 229-8599 to obtain Prior Authorization. When requesting Prior Authorization, you will need to furnish the following information:

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

4.4.2 Failure to Obtain Prior Authorization

If you do not obtain Prior Authorization as specified in section 4.4 above, claims for those Services will be denied and you will be responsible to pay for those Services.

4.5 TRAVEL REIMBURSEMENT BENEFIT

Subject to Prior Authorization, if you are unable to locate an In-Network Provider to provide Medically Necessary Covered Services for your specific condition within 50 miles of your home, the Plan will reimburse your travel expense to the nearest In-Network Provider within 300 miles of your home. Reimbursement will be based on the federal mileage reimbursement rate in effect on the date of service. Travel expense reimbursement is limited to $5,000 per Calendar Year. If an overnight stay is required, food and lodging are reimbursable up to $150 per diem (per day). Per diem expenses apply to the $5,000 travel expenses reimbursement maximum. This benefit includes travel reimbursement for transplant Covered Services.

4.6 MEDICAL COST MANAGEMENT

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

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

Under its medical cost management protocols and the criteria specified in this Member Handbook, Providence Health Plan may approve a substitution for a Covered Service under this Plan. A Substituted Service must:

1. Be Medically Necessary;
2. Have PEBB's written authorization of the Substituted Service for the Participant;
3. Be prescribed and approved by your treating Qualified Practitioner; and
4. Offer a medically therapeutic value at least equal to the Covered Service that would otherwise be performed or given.

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

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

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

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

4.6.1 Coverage of New Technology and New Application of Existing Technology

New technologies and new applications of existing technologies are evaluated and approved for coverage when they provide a demonstrable benefit for a particular illness or disease,

are scientifically proven to be safe and most effective, and there is no equally effective or less costly alternative.

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

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

Providence Health Plan has developed standards to guide the evaluation process and to ensure appropriate coverage determinations. New technology must minimally meet the following guidelines to be approved for coverage.

- Technology must improve health outcomes. The beneficial effects must outweigh any harmful effects on health outcomes. It must improve the length of life, ability to function or quality of life.
- Technology must be as beneficial as any established alternative. It should improve the net health outcome as much, or more, than established alternatives.
- Application of technology must be appropriate, in keeping with good medical standards, and useful outside of investigational settings.
- Technology must meet government approval to market by appropriate regulatory agency as applicable.
- Criteria must be supported with information provided by well-conducted investigations published in peer-reviewed journals. The scientific evidence must document conclusions that are based on established medical facts.
- Opinions and evaluations of professional organizations, panels, or technology assessment bodies are evaluated based on the scientific quality of the supporting evidence.

Technology Evaluation Process

A committee of medical directors with physician specialist advisors evaluates all new technology and determines coverage based on evidence for safety and efficacy. The committee relies upon a thorough review of pertinent medical literature and utilizes national technology review services that provide independent analysis of a new technology.

Expedited Review

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

4.7 MEDICALLY NECESSARY SERVICES

Members are entitled to comprehensive medical care within the standards of good medical practice. Providence Health Plan's medical directors and special committees of In-Network

Providers determine which Services are Medically Necessary, as described in section 14, Definitions. Services that do not meet Medically Necessary criteria will not be covered.

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

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

4.8 APPROVED CLINICAL TRIALS

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

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

The following costs are excluded:

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

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

4.9 HOW BENEFITS ARE APPLIED

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

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

4.10 DEDUCTIBLES, OUT-OF-POCKET MAXIMUMS AND MAXIMUM COST SHARES

Your Providence Choice Plan has In-Network Individual and Family Deductibles as well as Out-of-Network Individual and Family Deductibles; In-Network Individual and Family Out-of-

Pocket Maximums as well as Out-of-Network Individual and Family Out-of-Pocket Maximums; and In-Network Individual and Family Maximum Cost Shares.

4.10.1 Understanding Deductibles

Your Deductible is the dollar amount shown in the Benefit Summary that you are responsible to pay every Calendar Year when receiving most Covered Services before benefits are provided by the Plan. You pay Deductible amounts to your Qualified Practitioner after Providence Health Plan has processed your claim.

Certain Covered Services are covered without a Deductible. Please see your Benefit Summary for information about these Services.

Separate In-Network and Out-of-Network Deductibles: Your Plan has **Separate In-Network and Out-of-Network Deductibles**. An Individual and Family Deductible applies to Covered Services received using your In-Network benefit, and a separate Individual and Family Deductible applies to Covered Services received using your Out-of-Network benefit. **These In-Network and Out-of-Network Deductibles accumulate separately and are not combined.**

Individual Deductible: An Individual Deductible is the amount shown in the Benefit Summary that must be paid by an individual Member before the Plan provides benefits for Covered Services for that Member.

Family Deductible: The Family Deductible is the amount shown in the Benefit Summary that applies when three or more family members are enrolled in this Plan, and is the maximum Deductible amount that enrolled family members must pay. All amounts paid by enrolled family members toward their Individual Deductibles apply toward the Family Deductible. When the Family Deductible is met, no further Individual Deductibles will need to be met by any enrolled family members.

When the number of enrolled family members is less than three, the Individual Deductible applies to each enrolled Member.

Note: No Member will ever pay more than an Individual Deductible before the Plan begins paying for Covered Services for that Member.

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

- Services not covered by this Plan;
- Services in excess of any maximum benefit limit;
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges;
- Any costs you must pay if you do not follow Providence Health Plan's Prior Authorization requirements;
- Copayments or Coinsurance for any Supplemental Benefits you may have elected, such as vision.

Deductible Carry Over: Applicable charges for Covered Services used to meet any portion of the Deductible during the fourth quarter of a Calendar Year will be applied toward the next year's Deductible up to the maximum dollar amount stated in your Benefit Summary.

4.10.2 Understanding Out-of-Pocket Maximums

Separate In-Network and Out-of-Network Out-of-Pocket Maximums: Your Plan has **Separate In-Network and Out-of-Network Out-of-Pocket Maximums**. An Individual and Family Out-of-Pocket Maximum applies to Covered Services received using your In-Network benefit, and a Separate Individual and Family Out-of-Pocket Maximum applies to Covered Services received using your Out-of-Network benefit. **These In-Network and Out-of-Network Out-of-Pocket Maximums accumulate separately and are not combined.**

Individual Out-of-Pocket Maximum: Individual Out-of-Pocket Maximum means the total amount of Copayments and Coinsurance that a Member must pay in a Calendar Year, as shown in the Benefit Summary, before the Plan begins to pay 100% for Covered Services for that Member within that Calendar Year.
Family Out-of-Pocket Maximum: Family Out-of-Pocket Maximum means the total amount of Copayments and Coinsurance that a family of three or more must pay in a Calendar Year, as shown in the Benefit Summary, before the Plan begins to pay 100% for Covered Services for enrolled family members. When the combined Copayment and Coinsurance expenses of three or more enrolled Family Members meet the Family Out-of-Pocket Maximum, all remaining Individual Out-of-Pocket Maximums will be waived for the family for that Calendar Year.

When the number of enrolled family members is less than three, the Individual Out-of-Pocket Maximum applies to each enrolled Member.

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

The following out-of-pocket costs do not apply toward your Individual and Family In-Network or Out-of-Network Out-of-Pocket Maximums:

- Services not covered by this Plan;
- Services in excess of any maximum benefit limit;
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges;
- Copayments or Coinsurance for a Covered Service if indicated in the Benefit Summary as not applicable to the Out-of-Pocket Maximum;
- Additional Cost Tier Services;
- Deductibles, Copayments or Coinsurance payable under your Prescription Drug Benefit;
- Copayments or Coinsurance for Fertility Covered Services;
- Copayments or Coinsurance for elective abortion Services administered through Progyny;
- Copayments or Coinsurance for any Supplemental Benefits your Plan may have such as vision; and
- Any penalties you must pay if you do not follow the Plan's Prior Authorization requirements.

***IMPORTANT NOTE:** Covered Services indicated as not applicable to the Out-of-Pocket Maximum and that do not qualify as Essential Health Benefits are NOT eligible for 100% benefit coverage. The Copayment or Coinsurance for these Services as shown in the Benefit Summary remains in effect throughout the Calendar Year.

4.10.3 Understanding Maximum Cost Shares

Maximum Cost Share means the annual limit on cost sharing for Essential Health Benefits as established by the Patient Protection and Affordable Care Act (ACA). Deductibles, Copayments and Coinsurance paid by the Member for Essential Health Benefit Covered Services received In-Network apply to the Maximum Cost Share.

Maximum Cost Shares are separate from Out-of-Pocket Maximums and can only be met by Member costs for In-Network Covered Services that qualify as Essential Health Benefits. Essential Health Benefits encompass 10 broad categories:

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

Not all Services covered under the Plan qualify as Essential Health Benefits. If a Service does not qualify, it will not accumulate to the Maximum Cost Share and will be labeled as such in your Member materials. No costs for Covered Services received Out-of-Network apply to the Maximum Cost Share.

Member costs applied to Maximum Cost Shares will also apply to In-Network Out-of-Pocket Maximums.

Individual Maximum Cost Share: Individual Maximum Cost Share means the total amount of In-Network Copayments, Coinsurance and Deductible for In-Network Essential Health Benefit Covered Services that a Member must pay in a Calendar Year, as shown in the Benefit Summary, before we begin to pay 100%* for In-Network Essential Health Benefit Covered Services for that Member within that Calendar Year.

Family Maximum Cost Share: Family Maximum Cost Share means the total amount of Copayments, Coinsurance and Deductible for In-Network Essential Health Benefit Covered Services that a family of two or more must pay in a Calendar Year, as shown in the Benefit Summary, before we begin to pay 100%* for In-Network Essential Health Benefit Covered Services for enrolled family members. When the combined In-Network Copayment, Coinsurance and Deductible expenses of enrolled family members meet the Family Maximum Cost Share, all remaining Individual Maximum Cost Share will be waived for enrolled family members for that Calendar Year.

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

- Services that do not qualify as Essential Health Benefits;

- Services not covered by this Plan;
- Services in excess of any maximum benefit limit;
- Chiropractic Manipulation and Acupuncture Services;
- Fertility Services;
- Abortion Services administered by Progyny;
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges;
- Premiums and penalties; and
- Any costs you must pay if you do not follow Providence Health Plan's Prior Authorization requirements.

4.11 UNDERSTANDING PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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

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

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

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

You are protected from balance billing for:

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

Certain services at an In-Network Hospital, Independent Freestanding Emergency Department or Ambulatory Surgical Center
When you get services from an In-Network Hospital, Independent Freestanding Emergency Department or Ambulatory Surgical Center, certain Providers there may be Out-of-Network. In these cases, the most those Providers may bill you is your plan's In-Network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon,

hospitalist, or intensivist services. These Providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.

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

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

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

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

Your health plan generally must:

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

If you believe you have been wrongly billed, you may contact Collective Health Member Advocates.

Member Advocate Support:

Monday-Friday: 4:00 a.m. to 6:00 p.m. PT
Saturday: 7:00 a.m. to 11:00 a.m. PT
Sunday: Closed
Support Channel Type: Client Specific Phone Number, Chat

You may also contact the U.S. Department of Health and Human Services and file a complaint by calling 800-985-3059 (toll-free) or going to https://www.cms.gov/nosurprises/consumers.

4.12 NOTICE OF PROVIDER TERMINATION

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

5. COVERED SERVICES

This section describes Services that, when Medically Necessary and not otherwise excluded or limited, are covered under this Plan.

Benefits for the treatment of illness or injury when such treatment is provided by a Qualified Practitioner include the Covered Services that are listed in this section and shown in the Medical Benefit Summary. Covered Services for the diagnosis and treatment of Mental Health or Substance Use Disorder are described under Mental Health and Substance Use Disorder in section 5.5.

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

- Human Organ/Tissue Transplants;
- Restoration of Head/Facial Structures and Limited Dental Services;
- Temporomandibular Joint (TMJ) Services;
- Surgery and anesthesia for dental Services;
- Fertility Services;
- Bariatric surgery Services; and
- Genetic Testing and Counseling Services.

5.1 PROVIDER SERVICES

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

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

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

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

If you are unable to keep a scheduled appointment with your provider, please try to notify that office in advance. If not, you may be charged for the missed appointment. Missed appointment charges are not covered expenses under this Plan.

5.1.2 Telehealth Services

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

PEBB members have access to expert medical care anytime, anywhere through Galileo 24/7/365 Virtual Care. Galileo is a digital medical practice of full-time PCPs, Specialists, and Care Navigators who all collaborate on patient cases to deliver care across 20+ specialty areas (Pediatrics to Geriatrics including end-to-end Behavioral Health). Members can connect with board certified providers for everyday concerns or sudden health issues via chat, phone, or video. Set up your account today, so when you need care, Galileo is just a click away.

1. Create your Galileo account here: galileo.health/providence
2. Next, download the Galileo app & log in
3. Message Galileo doctors anytime you have a health concern or question
4. Share with your eligible dependents - each member needs their own account with a unique email address.

5.1.2.1 On-Demand Virtual Visits

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

5.1.2.2 Office Visits Virtually

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

5.1.2.3 Telemedicine Services

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

- Is Medically Necessary;
- Is provided by a Qualified Practitioner;
- Is determined to be safely and effectively provided using synchronous two-way interactive conferencing according to generally accepted health care practices and standards; and
- The application of technology used to provide the Telemedicine Service meet all standards required by state and federal laws governing the privacy and security of protected health information.

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

5.1.3 E-mail Visits

E-mail Visits are covered as shown in the Medical Benefit Summary. Not all Providers offer E-mail Visits. Medical doctors (MD), Doctors of Osteopathy (DO), Nurse Practitioners (NP) and Physician Associates (PA) are the only categories of providers approved for E-mail Visits. Providers who are authorized to provide E-mail Visits have agreed to use appropriate Internet security technology to protect your information from unauthorized access or release. To be eligible for the E-mail Visit benefit, you must have had at least one prior office visit with your Medical Home Provider within the last 12 months.

Covered E-mail Visits include, but are not limited to:

- Communications of a new or existing diagnosis or treatment when the equivalent Service received through an office visit would have led to a claims submission to be covered by the Plan;
- Communications by the Medical Home Provider about the management of complex chronic conditions that require extensive education and ongoing monitoring;
- Communications of treatment for relapses of a previous condition that involve extended dialogue and significant physician time and judgment;
- Discussion of lab results that require significant changes in medication or further testing; and
- Extended counseling when person-to-person contact would involve an unwise delay.

Examples of E-mail communications that do not qualify as E-mail Visits include, but are not limited to:

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

5.1.4 Telephone Visits

Plan covers scheduled audio-only Office Visits for patients with a Provider.

5.1.5 Administration of Anesthesia and Surgical Procedures

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

5.1.6 Immediate Care

Immediate Care is an extension of your Primary Care Provider's office, and provides additional access to treatment you need right away for an illness or injury that is not life

threatening. This includes, but is not limited to, minor sprains, minor cuts and burns, and ear, nose, and throat infections. Routine care, like periodic health exams and well-baby care, should be delayed until you can be seen by your Primary Care Provider.

Whenever you need immediate care, call your Primary Care Provider first. Your Primary Care Provider or the provider-on-call is always available, day or night. He or she may either suggest that you be seen at your Primary Care Provider's office, or direct you to an immediate care center, Urgent Care, or emergency care facility. See section 5.5 for coverage of Emergency Care and Urgent Care Services.

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

5.1.7 Retail Health Clinic

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

5.2 PREVENTIVE SERVICES

Preventive Services are covered as shown in the Medical Benefit Summary.

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

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

Note: Additional Plan provisions apply to some Services (e.g.: to be covered in full, routine physical examinations and well-baby care must be received from an In-Network Provider to be covered in full), see section 5.2.1. If you need assistance understanding coverage for

preventive Services under your Plan, please contact Collective Health Member Advocates at (855) 284-1368.

5.2.1 Physical Examinations and Well-Baby Care

Periodic health exams and well-baby care Services are covered in full only when you received In-Network. These Services are covered as stated in your Benefit Summary. Your provider will determine which tests are necessary for your physical exam according to your medical history and current health status. More frequent exams will be covered if your provider determines that they are necessary. Vision and hearing screening services are covered when performed during a periodic health examination or well-baby care examination. For a child to be eligible for benefits for routine newborn baby care, the child must be properly enrolled as outlined in section 3. Ancillary Services, such as immunizations, are covered at the specified benefit level when billed by the provider.

Recommended Guidelines:

Infants up to 30 months:	Up to 12 well-baby visits.
Children and Adolescents:	
3 years through 21 years:	One exam every year.
Adults:	
22 years through 29 years:	One exam every five years.
30 years through 49 years:	One exam every two years.
50 years and older:	One exam every year.

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

Physical Exams for Commercial Driver's License: (limited to the PEBB principal subscriber only and only when the exam is required for employment). Coverage is provided for a physical examination required to obtain a commercial driver's license when that examination is performed by a Qualified Practitioner. Your Plan covers Physical Exams for Commercial Driver's License in full.

5.2.2 Immunizations and Vaccinations

Benefits for immunizations and vaccinations are provided when they are consistent with accepted medical practice. However, coverage does not include immunizations or vaccinations required solely for insurance, employment, or licensing purposes, or for participation in camps, sports activities, recreational programs, college admission, travel, or passport requirements for foreign travel.

Visits to your Qualified Practitioner's office or Participating Pharmacy for immunizations or injections are subject to the Copayment or Coinsurance shown in the Benefit Summary. Some immunizations may require Prior Authorization. **A list of Participating Pharmacies is available at ProvidenceHealthPlan.com/Pharmacy.**

5.2.3 Gynecological Examinations

Benefits for gynecological examinations include breast, pelvic and pap examinations once every Calendar Year or more frequently for women designated high risk. Family Planning Services are covered separately (see section 5.2.5). Benefits also include follow-up exams for any medical conditions discovered during an Annual gynecological exam that requires additional treatment.

5.2.4 Mammograms

Mammograms are covered once every Calendar Year for women 40 years of age and older, or as recommended by the Qualified Practitioner. See section 5.10.6 for diagnostic and supplemental breast examinations.

5.2.5 Family Planning Services

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

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

- Intrauterine device (IUD) insertion and removal;
- Medical exams and consultation for family planning;
- Depo-Provera to prevent pregnancy;
- Diaphragm devices;
- Removal of implantable contraceptives;
- Oral contraceptives (birth control pills); and
- Over-the-counter contraceptive drugs, devices, and products approved by the federal Food and Drug Administration.

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

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

If you self-pay (without insurance) for over-the-counter contraceptives, you can submit a request for reimbursement. Please visit the My Collective Portal at join.collectivehealth.com/PEBB-php for more information.

For coverage of tubal ligation, see Elective Sterilization, section 5.2.6.

5.2.6 Elective Sterilization

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

- *In-Network:* Services are covered in full.
- *Out-of-Network:* Services are covered subject to the provisions of the applicable Out-of-Network benefit, e.g. your Inpatient or Outpatient Surgery benefit.

5.2.7 Prostate Cancer Screening Exams

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

5.2.8 Colorectal Cancer Screening Exams

Benefits for colorectal cancer screening examinations for Member age 45 or older include:

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

Screening examinations for Members designated as high risk are covered as recommended by a Qualified Practitioner.

For Members age 45 and older:

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

For Members under age 45:

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

5.2.9 Preventive Services for Members with Diabetes

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

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

5.2.10 Diabetes Self-Management Education Program

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

5.2.11 Nutritional Counseling

Nutritional counseling Services are covered by the Plan as shown in your Benefit Summary and include Medically Necessary nutritional counseling Services related to bariatric surgery prior to and following the surgery. Deductible, Copayments and Coinsurance are waived for Covered Services provided by an In-Network Provider. There is no Annual visit limit for In-Network Covered Services provided under this benefit.

5.2.12 Tobacco Cessation Services

Participation in the Alere Wellbeing Quit for Life® tobacco cessation program is covered in full. This program addresses tobacco dependence through a clinically proven, comprehensive approach to tobacco cessation that treats all three aspects of tobacco use – physical addiction, psychological dependence and behavioral patterns. An expert Quit Coach will create a quit plan for each program Participant that includes:

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

Quit for Life can be reached at 1-866-QUIT-4-LIFE (784-8454), 5 a.m. through 9 p.m. (Pacific time), seven days a week.

5.3 MATERNITY SERVICES

Your benefits include coverage for comprehensive maternity care.

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

<u>Covered Services include:</u>

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

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

**Newborn nursery care is a facility Service covered under the enrolled newborn's Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider

Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visits benefit. This Plan does not cover pediatric standby charges for a vaginal delivery.

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

NOTE: Newborn nursery care, newborn nurse home visits, and any other Services provided to your newborn are covered only when the newborn child is eligible and properly enrolled under this Plan within the time frames outlined in section 3.2.3 regarding Newborn Eligibility and Enrollment.

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

The services of a lay, unlicensed direct entry, or any other unlicensed midwife are not covered. If you are unsure whether or not the services of a particular midwife are covered under this Plan, please contact Collective Health Member Advocates at (855) 284-1368.

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

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

Maternity support Services: Members may attend classes to prepare for childbirth. These classes are held at Network Hospitals. Call the providence Resource Line at 503-216-7969 or visit www.ProvidenceHealthPlan.com for information on classes, specific dates, locations, registration and prices. Classes vary by geographic area. In addition, you can partner with Collective Health's Member Advocates and Care Navigation teams from preconception to postpartum. Clinical caregivers work with Members throughout high-risk pregnancies, fertility health journey, postpartum and even coordinate pediatric Services for the new baby. To learn more, call Collective Health Member Advocates at (855) 284-1368..

Member Advocate Support:
Monday-Friday: 4:00 a.m. to 6:00 p.m. PT
Saturday: 7:00 a.m. to 11:00 a.m. PT
Sunday: Closed
Support Channel Type: Client Specific Phone Number, Chat

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

Donor breast milk coverage: For infants medically or physically unable to receive maternal human milk or participate in chest/breast feeding, or whose parent is medically or physically unable to produce maternal human milk in sufficient quantities or caloric density or participate in chest/breast feeding, the Plan provides coverage for medically necessary donor human milk for inpatient use, when ordered by a licensed health care provider with prescriptive authority, or by an International Board Certified Lactation Consultant (IBCLC) certified by the International Board of Lactation Consultant Examiners.

5.3.1 Breastfeeding Counseling and Support

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

5.4 INPATIENT HOSPITAL AND SKILLED NURSING FACILITY SERVICES

A Deductible, Copayment or Coinsurance, whichever is applicable, will be applied once per Confinement, even if you are treated in more than one Hospital and/or Skilled Nursing Facility. Providence Health Plan must be notified as soon as reasonably possible following the onset of treatment for coverage to continue.

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

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

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

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

5.4.1 Inpatient Hospital Services

Benefits are provided as shown in the Medical Benefit Summary.

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

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

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

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

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

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

Your provider will determine your medically appropriate length of stay. Providence Health Plan may review this determination for Medical Necessity. If you choose to stay in the Hospital longer than your physician advises, you will be responsible for the cost of additional days in the Hospital.

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

<u>Members Affected by a Replacement, or Changes to, Group Coverage</u>
If you or an enrolled dependent is confined in the Hospital on your effective date of coverage, or if benefits under this Plan change during a period of Hospital Confinement, covered expenses will be based on the benefit in effect when the stay began. The benefit will continue until discharge from the Hospital or until any applicable limits have been reached, whichever is earlier.

5.4.2 Observation Care

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

5.4.3 Skilled Nursing Facility

Benefits are provided as shown in the Medical Benefit Summary for Covered Services from a Skilled Nursing Facility, limited to 180 visits per Calendar Year. Services must be prescribed by your Qualified Practitioner in order to limit Hospital Confinement by providing convalescent skilled medical and nursing Services which cannot be adequately provided through a home health program.

5.4.4 Inpatient Rehabilitative Care

Benefits are provided for physical, occupational and speech therapy, as shown in the Medical Benefit Summary, for Medically Necessary inpatient rehabilitation to restore or improve lost function following illness or injury. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition. Inpatient rehabilitation Services are limited to 30 days per Calendar Year. If Services are required following a head or spinal cord injury, or for treatment of a cerebral vascular accident (stroke), the limit may be increased to 60 days per Calendar Year. If a Member is hospitalized when rehabilitative Services begin, rehabilitative benefits will begin on the day treatment becomes primarily rehabilitative. Limits do not apply to Mental Health Covered Services. (See section 5.10.12 for coverage of Outpatient Rehabilitation Services.)

5.4.5 Inpatient Habilitative Care

Coverage is provided, as shown in the Benefit Summary, for Medically Necessary inpatient habilitative care. If a Member is hospitalized when habilitative Services begin, habilitative benefits will begin on the day treatment becomes primarily habilitative. All Services must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. Coverage is provided at the same benefit level as Inpatient Rehabilitative Care listed in your Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 5.10.12 for coverage of Outpatient Habilitative Services.)

5.5 MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

This Plan complies with Oregon and Federal Mental Health Parity.

5.5.1 Mental Health Services

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

Covered Services include diagnostic evaluation; individual and group therapy; inpatient hospitalization as stated in section 5.4; residential, intensive outpatient, or partial hospitalization Services.

For inpatient, residential, intensive outpatient, or partial hospitalization treatment services; Providence Health Plan must be notified as soon as reasonably possible following the onset of treatment for coverage to continue. For Out-of-Network services, see section 4.3.

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

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

5.5.2 Applied Behavior Analysis

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

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

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

Exclusions to ABA Services:

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

5.5.3 Substance Use Disorder Services

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

Covered Services include diagnostic evaluation; detoxification; individual and group therapy; inpatient hospitalization as stated in section 5.4, residential, intensive outpatient, or partial hospitalization Services when they are Medically necessary as determined by Providence Health Plan.

For inpatient, residential, intensive outpatient, or partial hospitalization treatment services; Providence Health Plan must be notified as soon as reasonably possible following the onset of treatment for coverage to continue. For Out-of-Network services, see section 4.3.

Common formulations of medications for medication-assisted treatment such as buprenorphine and naltrexone are a covered benefit when Medically Necessary. Benefits are provided as shown in the Benefit Summary. Treatments involving the use of Methadone are a Covered Service only when such treatment is part of a medically supervised treatment program.

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

5.6 OUTPATIENT HOSPITAL SERVICES, DIALYSIS, CHEMOTHERAPY, RADIATION THERAPY

Benefits are provided as shown in the Other Covered Services section of the Medical Benefit Summary and include outpatient Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 5.10.2 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for invasive or non-invasive surgical procedure, outpatient cardiac rehabilitation and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, radiation oncology, and therapeutic procedures as ordered by your Qualified Practitioner. We may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, we will not Prior Authorize the Services. For additional information about Prior Authorization, see section 4.4.

Injectable or infused medications may require a Prior Authorization. For additional information about Prior Authorization, see section 3.5. Some injectable medication may be required to be supplied by a contracted Specialty Pharmacy. Infused medications may need to be administered at a designated location or a preferred site of care (refer to Infusion Therapy Site of Care Policy and Drug List, which can be found at ProvidenceHealthPlan.com/pharmacy) or may need to be self-administered. A list of drugs, the Self-Administered Drug List, is available at ProvidenceHealthPlan.com/pharmacy. After a transition period, the member will need to self-administer at home and the prescription drug benefit applies. For more information, see section 13.1. Member may use home infusion for most therapies. Home Infusion services are available and are usually necessary for total parenteral nutrition (TPN).

Covered Services under these benefits do not include Services for Outpatient Rehabilitation. Please refer to those specific Services within section 5.10.12.

5.6.1 Self-Administered Chemotherapy

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

Self-administered chemotherapy is covered under your prescription drug benefit unless the Outpatient Chemotherapy coverage results in a lower out-of-pocket expense to you.

5.7 EMERGENCY CARE SERVICES

Benefits for Emergency Services are provided as described below and shown in the Benefit Summary. Emergency Care Services are provided both in and out of the Service Area. If an emergency situation should occur, you should take immediate action and seek prompt medical care. You should call 911 or the emergency number listed in the local telephone directory or go to the nearest Hospital emergency department.

5.7.1 Emergency Care

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

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

Coverage is provided without Prior Authorization for Emergency Medical Screening Exams and stabilization of an Emergency Medical Condition. Hospitalization for an Emergency Medical Condition requires notification to Providence Health Plan within 48 hours, or as soon as reasonably possible following the onset of the treatment in order for coverage to continue.

Definitions:

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

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

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

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

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

Your Plan benefits cover Emergency Services in the emergency room of any Hospital or Independent Freestanding Emergency Department.
If you or a Family Member believes that immediate assistance is needed for an Emergency Medical Condition, **call 911 or go to the nearest emergency room**. Tell the emergency personnel the name of your Primary Care Provider and show them Your Member ID Card.

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

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

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

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

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

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

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

5.7.2 Emergency Medical Transportation

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

5.7.3 Emergency Eye Care Services

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

5.7.4 Emergency Detoxification Services

Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a Substance Use Disorder treatment program, as stated in section 5.5.2, at the time Services are received. Prior Authorization is not required for emergency treatment; however, we must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to an In-Network Provider for continued inpatient care, the cost of Medically Necessary transportation will be covered.

5.8 URGENT CARE SERVICES

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

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

You are responsible for the urgent care Deductible and Copayment/Coinsurance, as shown in the Medical Benefit Summary, whenever you receive Urgent Care Services. Please be prepared to pay the Copayment/Coinsurance at the time you receive care. You are also responsible for the applicable Deductible and Copayment/Coinsurance shown in the Benefit Summary for any ancillary Services received, such as lab tests that are billed by the Medical Home provider.

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

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

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

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

Not all Out-of-Network Facilities will file a claim on a Member's behalf. If you receive Urgent Care Services from an Out-of-Network facility, you must submit a claim if the facility or provider does not submit it for you. See section 8.1.1.

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

Benefits for medical supplies, medical appliances, prosthetic and orthotic devices and Durable Medical Equipment (DME) are provided as shown in the Medical Benefit Summary when Medically Necessary as determined by the Plan. Providence Health Plan may authorize the purchase of an item if they determine the cost of purchasing an item would be less than the overall rental of the item. Services must be prescribed by your Qualified Practitioner. Luxury or upgrade (deluxe) equipment, backup or spare equipment, equipment which is primarily for the convenience of the Member or caregiver, self-help devices or training equipment, and equipment intended for the use outside a Member's home are not covered.

Necessary repair or replacement of covered medical supplies, medical appliances, prosthetic and orthotic devices and Durable Medical Equipment (DME) may be covered when the cost is not covered by a warranty, unless repair or replacement is due to Member negligence or intentional damage. The reasonable cost of repairing an item is covered as long as this cost does not exceed the purchase of a new piece of equipment or device. Replacement of covered items due to loss or theft, irreparable damage, or normal wear may be covered when approved by the Plan. Items that are replaced due to the availability of a newer or more efficient model are not covered unless Medically Necessary. Repair or replacement is covered if due to normal growth processes or to a change in your physical condition due to illness or injury.

5.9.1 Medical Supplies (Including Diabetes Supplies)

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

1. Medically Necessary supplies as ordered by your Qualified Practitioner, including, but not limited to, ostomy supplies, prescribed needles, syringes and chem strips. Non-sterile examination gloves used by you or your caregiver are NOT a covered medical supply.
2. Diabetes supplies, such as needles, syringes, continuous glucose monitors and blood glucose monitors, lancets and test strips, may be purchased through Providence Health Plan's Network medical supply providers under your DME benefit. See section 5.11.1 for coverage of select diabetes supplies and formulary insulin pumps under

your prescription drug benefit. Formulary, Prior Authorization, and quantity limits may apply – please see your Formulary for details. See section 5.9.4 for coverage of diabetic equipment such as insulin pump devices.

3. Medically Necessary Medical Foods for supplementation or dietary replacement including non-prescription elemental enteral formula for home use, when determined to be Medically Necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition. Medical foods are also covered for the treatment of Inborn Errors of Metabolism, as described in section 5.10.7. Medical foods do not include total parenteral nutrition (TPN), which is covered as described in section 5.10.2.

5.9.2 Medical Appliances

Benefits are shown in the Medical Benefit Summary for the following medical appliances:

1. Casts, braces and supportive devices when used in the treatment of medical or surgical conditions in acute or convalescent stages or as immediate post-surgical care.
2. Initial and replacement contact lenses, conventional (standard) intraocular lenses, prescription lenses or standard frame glasses, when required as a result of injury, illness or surgery, such as, but not limited to, cataract, corneal transplant surgery or for the treatment of keratoconus.
3. Rental of an oxygen unit used in the home for Members with significant hypoxemia who are unresponsive to other forms of treatment. The benefit is limited to three months from the initial date of Service unless there is clinical evidence of the need to continue.
4. Removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes.
5. Medical devices that are surgically implanted into the body to replace or aid function (including bilateral Cochlear Implants). If you receive a procedure to implant a medical device, you will be responsible for any Copayment or Coinsurance for the medical device in addition to any Copayment or Coinsurance for the procedure.
6. Other Medically Necessary appliances, including hearing aids and hearing assistance technology (HAT), as ordered by your Qualified Practitioner.

5.9.3 Prosthetic and Orthotic Devices

Benefits are provided for prosthetic and orthotic devices as shown in the Medical Benefit Summary. Coverage is limited to those prosthetic and orthotic devices that are Medically Necessary and included in the Medicare fee schedule for Durable Medical Equipment, Prosthetics, Orthotics and Supplies. Covered Services include rigid or semi-rigid devices used for supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back, or neck or an artificial limb device or appliance designed to replace in whole or in part an arm or a leg; breast implants following mastectomy; artificial eyes; and maxillofacial prosthetic devices for the restoration and management of head and facial structures. (For coverage of removable custom shoe orthotics, see section 5.9.2.)

5.9.4 Durable Medical Equipment (DME)

Benefits are provided for DME as shown in the Medical Benefit Summary. Covered Services may include Medically Necessary equipment such as a hospital bed, non-motorized

wheelchair, ventilator, and similar equipment as approved by Providence Health Plan. Covered Services for DME do not include items that are primarily and customarily used for a non-medical purpose or which are used for environmental control or enhancement (whether or not prescribed by a physician).

5.10 OTHER COVERED SERVICES

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

5.10.1 Allergy Shots and Allergy Serums

Allergy shots and allergy serums are covered as shown in the Medical Benefit Summary. The following tests and treatments are covered only when such therapy or testing is approved by The American Academy of Allergy and Immunology, or The Department of Health and Human Services or any of its offices or agencies: therapy and testing for treatment of allergies including, but not limited to, Services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts and neutralization. Some injectable medications may require Prior Authorization.

5.10.2 Injectable and Infused Medications

Injectable and infused medications received in your Provider's office are covered, as shown in your Benefit Summary. Some injectable medications may require Prior Authorization, as listed in the Medical benefit drug Prior Authorization list available at ProvidenceHealthPlan.com/pharmacy or by calling Collective Health Member Advocates at 855-284-1368. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. See section 5.1.1 for coverage of infusion at Outpatient Facilities.

5.10.3 Bariatric Surgery

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

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

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

5.10.4 Diagnostic Pathology, Radiology Tests, High Tech Imaging and Diagnostic Procedures

Benefits are as shown in the Medical Benefit Summary and include inpatient and outpatient diagnostic pathology (lab), high tech imaging (such as PET, CT, CTA. MRI and MRA), radiology (x-ray) tests, echocardiography, and other Medically Necessary diagnostic procedures. Covered Services include contrast materials (dyes) that may be required for a diagnostic procedure. All high tech imaging Services and Nuclear Cardiac Study Services must be Prior Authorized by Providence Health Plan or the Plans authorizing agent

5.10.5 Sleep Study Services

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

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

5.10.6 Diagnostic and Supplemental Breast Examinations

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

Supplemental breast examinations include breast magnetic resonance imaging or a breast ultrasound. These exams are used to screen for breast cancer when there is no abnormality seen or suspected but there is an increased risk of breast cancer based on personal or family medical history or other factors.

See section 5.2.4 for annual preventive mammograms.

5.10.7 Home Health Care Benefit

Benefits for home health care Covered Services are shown in the Medical Benefit Summary, limited to 180 visits per Calendar Year and are described below. We will provide benefits for home health care as an alternative to hospitalization with consent of the Member. A Home Health Provider must provide Services at your home under a home health care plan. Nothing in this provision will increase benefits to cover home health care Services that are not otherwise covered under this Plan.

Each visit by a person providing Services under a home health care plan or evaluating the need for or developing a plan is considered one home health care visit. Up to four consecutive hours in a 24-hour period of home health care Service is considered one home health care visit. A home health care visit of more than four hours is considered one visit for every four hours or part thereof.

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

- The home health care Services will be provided or coordinated by a state-licensed or Medicare-certified Home Health Agency or certified rehabilitation agency; and

- Providence Health Plan determines the Services to be Medically Necessary.

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

If the above criteria are not met, NO benefits will be provided under this Plan for home health care.
Rehabilitation Services provided under an authorized home health care plan will be covered as home health care Services.

Home health care benefits do NOT include:

- Charges for mileage or travel time to and from your home;
- Wage or shift differentials for Home Health Providers; or
- Charges for supervision of Home Health Providers.

5.10.8 Hospice Care Benefit

Benefits are included for hospice care as shown in the Medical Benefit Summary and described below.

In addition, the following criteria must be met:

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

When the above criteria are met, the Plan will provide benefits for a full range of Covered Services that are required to be included in a certified hospice care program. Covered Services include the following:

- Nursing care provided by or under the supervision of a registered nurse;
- Medical social services provided by a medical social worker who is working under the direction of a physician, including counseling for the purpose of helping you and your caregivers adjust to the approaching death;
- Services provided by your Qualified Practitioner or a physician associated with the hospice program;
- Durable Medical Equipment (DME), medical supplies and devices, including medications used primarily for the relief of pain and control of symptoms related to the terminal illness;
- Home health aide Services for personal care, maintenance of a safe and healthy environment and general support to the goals of the plan of care;
- Rehabilitation therapies provided for purposes of symptom control or to enable you to maintain activities of daily living and basic functional skills;
- Continuous home care during a period of crisis in which you require skilled intervention to achieve palliation or management of acute medical symptoms; and
- Up to 120 hours of respite care.

Services not specified above are excluded from coverage.

5.10.9 Inborn Errors of Metabolism

Benefits are provided for Covered Services as shown in the Medical Benefit Summary based upon the type of Services received for diagnosing, monitoring and controlling inborn errors of metabolism, including, but not limited to: phenylketonuria (PKU); homocystinuria; citrullinemia; maple syrup disease; and pyruvate dehydrogenase deficiency; that involve amino acid, carbohydrate and fat metabolism for which medically standard methods exist, including quantification of metabolites in blood, urine, spinal fluid or enzyme or DNA confirmation in tissues. Covered Services include clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. (For coverage of medical foods, see section 5.9.1.)

5.10.10 Podiatry/Foot Services

Benefits include Covered Services of a podiatrist or other Qualified Practitioner and are provided as shown in the Physician/Provider Services section of the Medical Benefit Summary. Covered Services include, but are not limited to, the fitting and follow up exam for removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom shoe orthotics are covered as stated in section 5.9.2 for Medical Appliances. Covered Services do not include routine foot care and the removal of corns or calluses, unless you have diabetes.

5.10.11 Reconstructive Surgery

Reconstructive Surgery is covered for conditions resulting from congenital defects, developmental abnormalities, trauma, infection, tumors or disease. Reconstructive surgery may be performed to correct a functional impairment in which the special, normal or proper action of any body part or organ is damaged; when necessary because of accidental injury or to correct scars or defects from accidental injury; or when necessary to correct scars or defects to the head or neck resulting from covered surgery. Benefits are covered as those Services listed in the Medical Benefit Summary based upon the type of Services received. All Covered Services for Reconstructive Surgery must be Prior Authorized. For Reconstructive Surgery of head or facial structures and limited dental Services, see section 6.2.

5.10.12 Reconstructive Surgery of the Breast

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

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

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

Breast reduction services are covered when medically necessary. Breast surgeries for cosmetic purposes are excluded as described in section 7.

Limitations to this benefit do not apply to Mental Health or Substance Use Disorders. If you have additional questions about your WHCRA benefits, please contact Collective Health Member Advocates.

5.10.13 Outpatient Rehabilitative Services

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

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

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

Exclusions to Outpatient Services:

- Exercise programs;
- Rolfing, polarity therapy and similar therapies; and
- Rehabilitation Services provided under an authorized home health care plan as stated in section 5.10.4.

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

5.10.14 Outpatient Habilitative Services

Coverage is provided, as shown in the Benefit Summary, for Medically Necessary outpatient habilitative Services. All Services are subject to review for Medical Necessity and must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. Coverage is provided at the same benefit level as Outpatient Rehabilitative Care listed in your Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 5.4.5 for coverage of Inpatient Habilitative Care.)

5.10.15 Abortion Services

Covered Services include elective abortion. Claims are processed under a separate trading partner agreement with Progyny, as shown in section 8.

5.10.16 Chiropractic Manipulation

Coverage is provided for chiropractic manipulation, subject to the following limitations:

- Services must be Medically Necessary and within the Qualified Practitioner's scope of license; and
- Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition and are subject to the visit limit stated in the Benefit Summary.

5.10.17 Acupuncture

Coverage is provided for acupuncture, subject to the following limitations:

- Services must be Medically Necessary and within the Qualified Practitioner's scope of license; and
- Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition and are subject to the visit limit stated in the Benefit Summary.

5.10.18 Massage Therapy

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

5.10.19 Gender Affirming Treatment

Gender-affirming treatment means a procedure, service, drug, device or product that a physical or behavioral health care provider prescribes to treat an individual for incongruence between the individual's gender identity and the individual's sex assignment at birth. Benefits are provided for gender-affirming services. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. Gender-affirming surgery is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply to certain inpatient procedures. Please see section 4.4 for more information on services requiring Prior Authorization.

5.10.20 Hearing Loss Services

Definitions:

Cochlear Implant

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

Hearing Aid

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

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

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

Cochlear implants:
Cochlear implants for one or both ears, including fitting, programming, reprogramming, replacement and repair. The devices are covered under the Durable Medical Equipment benefit. The implantation services are covered under the Surgery and applicable Facility benefit. These services and devices are not subject to your Deductible in-network.

Hearing aids & related accessories:
Medically Necessary external hearing aids and devices, as prescribed, fitted, and dispensed by a licensed audiologist or a hearing aid/instrument specialist. Hearing aids and devices are covered under the Medical Appliances benefit. This benefit is available for one hearing aid per ear every three Calendar Years for all Members. Hearing aid batteries are covered for one box per hearing aid per Calendar Year. These services and devices are not subject to your Deductible in-network.

Diagnostic & Treatment Services:
Medically Necessary diagnostic and treatment services, including office visits for hearing tests appropriate for member's age or development need, hearing aid checks, and aided testing. Services are covered under the applicable benefit level for the service received. For example, office visits with an audiologist are covered under the Specialist office visit benefit. These services and devices are not subject to your Deductible in-network.

Hearing Assistance Technology:
- Bone conduction sound processor headbands and prosthetic parts, if necessary for appropriate amplification of hearing loss. This benefit is available once every three Calendar Years for all Members.
- Hearing assistive technology systems, if necessary, for appropriate amplification of hearing loss. This benefit is available once every three Calendar Years for all Members.
- Necessary repair or replacement of such devices when the cost is not covered by a warranty.
- These services and devices are not subject to your Deductible in-network.

Limits to Hearing Loss Services
Coverage for hearing loss services are provided in accordance with state and federal law.

5.10.21 Wigs

One wig every Calendar Year will be covered for Members who have undergone chemotherapy or radiation therapy or are experiencing pharmaceutical drug-induced

Alopecia at the Medical Equipment, Supplies and Devices benefit level listed in your Benefit Summary. A wig is a full cranial hair prosthesis option to use as a hair loss solution or hair replacement. Wigs may be purchased from any wig supplier. Wig suppliers may require Members to pay for items and submit the paid receipt to Providence Health Plan for reimbursement. For information about submitting claims, see section 8.1.

5.10.22 Biofeedback

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

5.10.23 Fertility Preservation Services

The Plan covers Fertility Preservation for members with sickle cell disease or where treatment related to cancer conditions may cause irreversible infertility, as recommended by clinical evidence-based guidelines such as those of the National Comprehensive Cancer Network (NCCN) and as outlined in our medical policy.

Covered Services include the following:

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

For Fertility treatment, including in-vitro fertilization, please see Section 6.3.

5.10.24 Facial Electrolysis

Coverage is provided for Facial Electrolysis services to treat hirsutism for members with Polycystic Ovary Syndrome (PCOS). Services must be Medically Necessary to qualify for coverage.

5.10.25 Other Medical Services and Devices

This Plan covers support for implantable and external medical devices that are vital to your well-being. Coverage for initial device setup, device training, and evaluation of device functionality is provided when performed by a Qualified Practitioner. This coverage is subject to your In-Network and Out-of-Network coinsurance, as shown in your Benefit Summary. Coverage includes, but is not limited to, cardiac rhythm management devices, eye tracking devices for amblyopia, and both speech and non-speech generating devices.

5.11 PRESCRIPTION DRUG BENEFIT

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

The following are considered "Prescription Drugs":

1. Any medicinal substance which bears the legend, "RX ONLY" or "Caution: federal law prohibits dispensing without a prescription";
2. Any medicinal substance of which at least one ingredient is a federal legend drug in a therapeutic amount;

3. Any medicinal substance that the Food and Drug Administration (FDA) reviews for safety and benefit. Products labeled "Not evaluated by the FDA" are excluded;
4. Any compounded drug product prepared using pharmaceutical-grade active ingredients, which are reviewed by the FDA for safety and benefit;
5. Insulin; and
6. Any medicinal substance which has been approved by Oregon's Health Evidence Review Commission (HERC) as effective for the treatment of a particular indication.

Self-Administered Prescription Drug Definition

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

Select self-administered injectable prescription drugs are medications which have been identified as being medically appropriate for administration by a patient or their caregiver, safely and effectively, without medical supervision. Certain injectable prescription drugs considered to be usually self-administered by the patient or their caregiver are excluded from coverage under the medical benefit without Prior Authorization.

- A transition period may be allowed for a member to receive the drug at the Provider's office, clinic, or facility. After this transition period, the member will need to self-administer at home and your Prescription Drug Benefit applies.
- A list of these drugs, the Self-Administered Drug List, can be found on the Providence Pharmacy Resources website at ProvidenceHealthPlan.com/Pharmacy.

Medically-Administered Prescription Drug Definition

Prescription Drugs, including oral, topical and injectable medications delivered, injected or administered to you by a physician, other provider, or trained person in a Provider's office or other facility are not covered under your Prescription Drug Benefit. Prescription drugs administered in a Provider's office or other facility are subject to the applicable benefit. For example, Prescription Drugs delivered in a Provider's Office are subject to your Allergy Shots and Allergy Serums benefit (see section 5.10.1). For details about Injectable and Infused Medications, refer to sections 5.10.2, 5.6, and 5.11.1.

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

5.11.1 Using Your Prescription Drug Benefit

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

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

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

Participating Pharmacies are designated as retail, preferred retail, specialty and mail-order pharmacies. To view a list of our Participating Pharmacies, visit our website atmy.collectivehealth.com. You also may contact Collective Health Member Advocates at 855-284-1368.

- Please present your Member ID Card to the Participating Pharmacy at the time you request Services. If you have misplaced or do not have your Member ID Card with you, please ask your pharmacist to call us.
- All covered Services are subject to the Deductible, Copayments and/or Coinsurance listed in your Benefit Summary. Benefit maximums may also apply as defined in the handbook.
- The amount paid by a manufacturer discount and/or copay assistance programs will apply towards your Calendar Year Deductibles and Out-of-Pocket Maximums
- Prescription Drug Services are subject to the Prescription Drug Deductible and Copayment amounts shown in the Prescription Drug Benefit Summary (does not apply to Value Drugs).
- Prescription Drug Deductible and Copayment amounts do not apply to the medical Calendar Year Out-of-Pocket Maximum and are due at the time of purchase.
- Participating Pharmacies may not charge you more than your Copayment, except when Deductible and/or coverage limitations apply. Please contact Collective Health Member Advocates if you are asked to pay more or if you or the pharmacy have questions about your Prescription Drug benefits or need assistance processing your prescription.
- If your brand-name benefit includes a Copayment or a Coinsurance and you or your provider request a brand-name drug, you will be responsible for the difference in cost between the brand-name drug and the generic drug, in addition to the brand Copayment or Coinsurance unless it is determined Medically Necessary. Your total cost, however, will never exceed the cost of the drug. This cost difference does not apply to the Calendar Year Deductible or Out-of-Pocket Maximum, and you will continue to be responsible for the difference in cost after your Out-of-Pocket Maximum is met.
- Copayments or Coinsurance are due at the time of purchase. If the cost of your Prescription Drug is less than your Copayment, you will only be charged the cost of the Prescription Drug.
- You may be assessed multiple Copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- If you are covered under this Plan and another pharmacy plan administered by Providence Health Plan, the Participating Pharmacy will automatically coordinate coverage. You will need to present your primary insurance card to the pharmacy before filling the prescription and notify Collective Health Member Advocates of the other

coverage so it can be documented in your file. If your other pharmacy coverage is not administered by Providence Health Plan, you will need to submit a claim form for reimbursement. Please contact Collective Health Member Advocates if you or the pharmacy have questions.

- You may purchase up to a 90-day supply of each maintenance drug at one time using a Participating mail service pharmacy, as described under the Participating Mail Order Pharmacy section or a Preferred Retail Pharmacy. Not all Prescription Drugs are covered for more than a 30-day supply, including compounded medications, drugs obtained from specialty pharmacies, and limited distribution pharmaceuticals. To obtain prescriptions by mail, your physician or provider can call in the prescription or you can mail your prescription along with your Member ID number to a Participating mail-order pharmacy. To see a list of Participating mail order pharmacies, please visit Providence Health Plan's website at ProvidenceHealthPlan.com/pharmacy. (Not all prescription drugs are available through the mail order pharmacies.
- Diabetes supplies (such as test strips and select continuous glucose monitors) and inhalation extender devices may be obtained at a Participating Pharmacy. Refer to your formulary for a list of diabetes supplies that may be covered under your prescription drug benefit when obtained at a pharmacy. Diabetic supplies obtained at a DME provider are considered medical supplies and devices.
- Select self-administered injectable medications are not covered when supplied in a provider's office, clinic or facility. Medications listed on the Self-Administered Drug list may be administered by a healthcare provider in a provider's office, clinic, or facility for a transition period, and benefits in section 5.6.1 apply. Please refer to the Providence Pharmacy Resource website at ProvidenceHealthPlan.com/pharmacy for the Self-Administered Drug list. After this transition period, you will need to self-administer at home and your prescription drug benefit applies.
- Injectable medications received in your Provider's office are covered under section 5.10.1.
- Medications for the treatment of sexual disorders or dysfunctions are covered as outlined in your Benefit Summary.
- Infusions, including infused medications, received at Outpatient Facilities are covered under section 5.6.
- Some prescription drugs require Prior Authorization or an exception to the Formulary in order to be covered; these may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in our Prescription Drug Formulary available on our website at ProvidenceHealthPlan.com/pharmacy or by contacting Collective Health Member Advocates.
- Providence Health Plan will provide Members prescription synchronization services for maintenance medications. Upon Member or provider request, the Plan will coordinate with Members, providers, and the dispensing pharmacy to synchronize maintenance medication refills so Members can pick up maintenance medications on the same date. Members will be responsible for applicable Copayments, Coinsurances, and Deductibles.
- Certain medications that are taken regularly called maintenance medications and also drugs listed on the value tier, need to be filled from either an in-network mail-order pharmacy or a preferred retail 90 pharmacy. Getting a 90-day supply at a preferred retail or mail order pharmacy saves money because you pay only 2 ½

copays instead of 3. Plus, value drugs have a $0 copay when you use in-network mail order service or a preferred Retail 90 pharmacy. The preferred retail 90 pharmacy network includes all preferred pharmacies. If you choose to not receive a 90 day supply of your maintenance or value medication at a preferred retail 90 or mail order pharmacy, you will be responsible for the full cost of the drug.

5.11.2 Use of Out-of-Network Pharmacies

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

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

If your claim is approved, the Plan will reimburse you the cost of your prescription up to the Participating Pharmacy contracted rates, subject to the terms of this Plan and the Prescription Drug Benefit Summary, less your applicable Copayment. You are responsible for any amounts above Providence Health Plan's contracted rates. Your reimbursement will be mailed directly to you.

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

5.11.3 Prescription Drug Formulary

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

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

Not all FDA-approved drugs are covered by Providence Health Plan. Non-formulary drug requests require a formulary exception, must be FDA-approved, Medically Necessary, and require by law a prescription to dispense. (See Section 8.1 under Claims Involving Prior Authorization and Formulary Exception.)

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

5.11.4 Prescription Drugs

Generic and Brand-Name Prescription Drugs

Both generic and brand-name drugs are covered as specified in this section. In general, generic drugs are subject to lower Copayment amounts than brand-name drugs. Please refer to the Prescription Drug Benefit Summary for your Copayment information.

Generic medication means a prescription medication that is:

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

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

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

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

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

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

Value drugs means commonly used medications for treating chronic conditions such as diabetes, high blood pressure, high cholesterol, heart disease, depression, asthma and other breathing disorders. These medications are on our formulary, may be generic or brand-name, and are considered first-line treatments for many conditions. Your prescription drug Deductible and Copayment amounts do not apply to Value drugs.

Affordable Care Act Preventive Drugs

In accordance with the Affordable Care Act (ACA) your plan covers, at no cost to you, certain preventive medications, including contraceptives, both prescription and Over-the-counter, when these medications are purchased from Participating Pharmacies. ACA preventive drugs your Plan covers are listed in your formulary. Over-the-counter ACA preventive drugs received from Participating Pharmacies will not be covered in full under the ACA preventive benefit without a written prescription from your Qualified Practitioner. However, over-the-counter contraceptives do not require a written prescription pursuant to Oregon state law.

5.11.5 Prescription Drug Quantity

Prescription dispensing limits, including refills, are as follows:

- Topicals, up to 60 grams;
- Liquids, up to eight ounces;
- Tablets or capsules, up to 100 dosage units;
- Multi-use or unit-of-use, up to one container or package; as prescribed, not to exceed a 30 consecutive day supply, whichever is less;
- FDA-approved women's prescription contraceptives: up to 3-months initial dispensing, then up to 12-months subsequent dispensing at any of our Participating Pharmacies; and
- Opioids up to 7 days initial dispensing.

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

5.11.6 Participating Mail Order and Preferred Retail Pharmacies

Up to a 90-day supply of prescribed maintenance drugs (drugs you have been on for at least 30 days and that you anticipate continuing on in the future) purchased from a Participating mail order or preferred retail Pharmacy will be covered subject to the following specific provisions:

1. Qualified drugs under this program will be determined by Providence Health Plan. Not all drugs are available through mail order pharmacy.
2. Not all maintenance prescription drugs are available in 90 day allotments.
3. Copayment(s) will be applied to the quantity stated in the Prescription Drug Benefit Summary.

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

To purchase prescriptions by mail, your physician or provider can call in the prescription or you can mail your prescription along with a notation of your Providence Health Plan ID number to a Participating mail order pharmacy. Participating mail order information is available on the Providence Health Plan website at ProvidenceHealthPlan.com/pharmacy.

5.11.7 Specialty Pharmacy Variable Copay Program

Many specialty medications have manufacturer programs which provide financial assistance to patients in the purchase of the medication. When a financial assistance program is available from a prescription drug manufacturer for a specialty medication, the plan requires that you participate in the program. Failure to complete the enrollment process for participation will result in a higher copayment/coinsurance and/or penalty, which can exceed the regular plan benefit cost shares. Only your actual out-of-pocket payments will count toward your Deductible or Out-of-Pocket Maximum. Manufacturer-funded financial assistance will not be considered true out-of-pocket costs for plan participants and will not

apply to Deductible and Out-of-Pocket Maximums. For medications not subject to this program, regular plan benefits will apply.

5.11.8 Prescription Drug Limitations

Prescription drug limitations are as follows:

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

medications covered in full by your Plan are the right ones for you, you may request coverage for a similar medication at $0 Cost-Share by submitting a Prior Authorization.

8. Vacation supply medication refill overrides are limited to a 30-day supply for active PEBB employees only.
9. A 30 day supply medication refill override may be granted if you are out of medication and have not yet received your drugs from a participating mail order pharmacy.

5.11.9 Prescription Drug Exclusions

In addition to the limitations and exclusions set forth in this Member Handbook, Prescription Drug Exclusions are as follows:

1. Drugs or medicines delivered, injected, or administered to you by a physician or other provider or another trained person (see section 5.10.1);
2. Drugs prescribed that do not relate to the prevention or treatment of a covered illness or injury;
3. Fluoride for Participants over 16 years of age;
4. Drugs that are not provided in accordance with the Providence Health Plan's formulary management program or are not provided according to Providence Health Plan's medical policy, unless approved in the exception process;
5. Topical therapies used in the treatment of fungal nail conditions;
6. Over-the-Counter (OTC) drugs or vitamins that may be purchased without a provider's written prescription, except as required by state or federal law;
7. Prescription drugs, including prescription combination drugs, that contain OTC products or are available in an OTC therapeutically similar form;
8. Drugs dispensed from pharmacies outside the United States, except when prescribed for Urgent/Immediate Care and Emergency Medical Conditions or as required by state or federal law;
9. Drugs, which may include prescription combination drugs, placed on prescription-only status by federal or state mandate outside of required FDA-status assignment (e.g., OTC drugs such as Sudafed®); and
10. Replacement of lost, stolen, or damaged medication;
11. Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy's standard packaging for the place of service submitted;
12. Drugs dispensed or compounded by a pharmacist that do not have at least one FDA approved medication in therapeutic amount;
13. Drugs used for cosmetic purposes;
14. Drugs used for weight loss;
15. Drugs used to treat hair loss, except for treatment for severe alopecia areata;
16. Drug kits, unless the product is available solely as a kit. Kits typically contain a pre-packaged drug along with items associated with the administration of the drug (*e.g.*, gloves, shampoo);
17. Drugs that are not approved by the Food and Drug Administration (FDA) or that are designated as "less than effective" by the FDA, also known as "DESI" drugs;
18. Early refill of eye drops, except when there is a change in directions by your provider, or if synchronizing your prescription refills. This exclusion does not apply to eye drops prescribed for the treatment of glaucoma; and
19. For drugs obtained at in-network pharmacies without using your pharmacy benefit, reimbursement is limited to our in-network contracted rates, except in the case of Urgent/Emergent situations. This means you may not be reimbursed the full cash

price you pay to the pharmacy. Drugs obtained from out-of-network pharmacies are not eligible for reimbursement, except in the case of Urgent/Emergent situations.

5.11.10 Prescription Drug Disclaimer

The Plan and Providence Health Plan are not liable for any claim, injury, demand, or judgment based on tort or other grounds (including, but not limited to, warranty or merchantability) arising out of or in any connection with the sale, compounding, dispensing, manufacturing, or use of any prescription drug covered under this Plan.

6. LIMITATIONS FOR SPECIFIED COVERED SERVICES

There are limitations on the benefits available under this Plan for the treatment of certain conditions and the use of certain procedures. This section describes these limitations.

6.1 HUMAN ORGAN/TISSUE TRANSPLANTS

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

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

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

6.1.1 Covered Services

Covered Services for transplants are limited to Services that:

1. Are Prior Authorized and determined by Providence Health Plan to be Medically Necessary and medically appropriate according to national standards of care;
2. Are provided at a facility approved by Providence Health Plan or under contract with Providence Health Plan (Transplant Services are not covered Out-of-Network);
3. Involve one or more of the following organs or tissues:
    - Heart
    - Lung
    - Liver
    - Kidney
    - Pancreas
    - Small bowel
    - Autologous hematopoietic stem cell or bone marrow
    - Allogeneic hematopoietic stem cell or bone marrow; and
4. Are directly related to the transplant procedure, including Services that occur before, during and after the transplant procedure.

Covered Services for transplant recipients include medical Services, Hospital Services, medical supplies, medications and prescription drugs while hospitalized, diagnostic modalities, prosthesis, high dosage chemotherapy for stem cell/bone marrow transplants, and travel expenses.

For travel expense reimbursement, see section 4.5.

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

- Initial evaluation of the donor and related program administration costs;
- Preserving the organ or tissue;

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

6.1.2 Benefits for Donor Costs

Benefits for donor or self-donor costs are payable as long as the recipient is covered by the Plan.

6.1.3 Benefits for Transplant Facility Services Provided to the Organ Recipient

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

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

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

6.1.4 Benefits for Outpatient Medications

Outpatient prescription medications for transplant-related Services, including anti-rejection (immunosuppressive) drugs, are covered under the outpatient prescription drug benefits of this Plan, as specified in section 5.11.

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

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

6.1.6 Transplant Prior Authorization

(See also section 4.4)

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

- Initial consultation;
- Evaluation;
- Transplant facilities;
- Donor evaluation;
- Donor Services;
- High-dose chemotherapy administered prior to the transplant
- HLA typing;
- Pre-transplant care;
- Self-donation Services;
- Transplant Services; and
- Follow-up treatment.

6.1.7 Transplant Exclusions

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

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

6.2 RESTORATION OF HEAD/FACIAL STRUCTURES; LIMITED DENTAL SERVICES

Covered Services are limited to those Services that are Medically Necessary for the purpose of controlling or eliminating infection, controlling or eliminating pain, or restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic services to improve on the normal range of conditions. Medically Necessary Covered Services include restoration and management of head and facial structures, including teeth, dental implants and bridges that cannot be replaced with living tissue and that are defective because of trauma, disease or birth or development deformities, not including overbite, crossbite, malocclusion or similar developmental irregularities of the teeth or jaw.

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

Exclusions that apply to Covered Services include:

- Cosmetic Services not considered Medically Necessary;
- Services rendered to improve a condition that falls within the normal range of such conditions;
- Routine Orthodontia;
- Services to treat tooth decay, periodontal conditions and deficiencies in dental hygiene;
- Removal of impacted teeth;
- The making or repairing of dentures;
- Orthognathic surgery, except when Medically Necessary, to treat developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth; and
- Services to treat temporomandibular joint syndrome, including orthognathic surgery, except as specified in the following section of this Member Handbook.

6.2.1 Temporomandibular Joint (TMJ) Services

Benefits are provided for TMJ Services using your In-Network benefits as shown in the Medical Benefit Summary. Applicable benefits apply to the Covered Services below:

- A diagnostic examination including a history, physical examination and range of motion measurements, as necessary;
- Diagnostic x-rays;
- Physical therapy of necessary frequency and duration, limited to 20 visits per Calendar Year;
- Therapeutic injections; and
- Therapy utilizing an appliance/splint which does not permanently alter tooth position, jaw position or bite. Benefits for this therapy will be based on the use of a single appliance/splint, regardless of the number of appliances/splints used in treatment. The benefit for the appliance splint therapy will include office visits, diagnostic Services, purchase of appliance/splint, and adjustments.

TMJ Services are covered under your In-Network benefits at the applicable benefit level for the Services received. Out-of-Network benefits do not apply to TMJ Services (if there are no in-network providers available, refer to Section 4.4.1 Prior Authorization Requests for Out-of-Network Services). Covered Services for TMJ conditions do not include dental or orthodontia Services.

6.2.2 Outpatient Hospitalization and Anesthesia for Limited Dental Services

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

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

Dental Services are excluded.

6.3 FERTILITY SERVICES

Coverage for Fertility Services is provided, as shown in the Medical Benefit Summary.

Covered Services include the following:

- Comprehensive consultations twice per year, which include office visits as well as diagnostic and lab tests
- One Progyny Smart Cycle with option to restart cycle if first is unsuccessful
- Progyny RX, which includes a simplified authorization process, next day medication delivery, and drug counseling and support
- Intrauterine insemination (IUI)
- In vitro fertilization (IVF)
- Preconception carrier screening
- Preimplantation Genetic Testing for Aneuploidy (PGT-A) and Monogenic/Single Gene Defect (PGT-M)
- Pregnancy Gap Coverage available with a Progyny provider for post-implantation monitoring services in the first 8 to 12 weeks of pregnancy
- Sperm washing and preparation
- Storage coverage for legacy tissue
- Tissue transportation from an Out-of-Network facility to an In-Network facility
- Telehealth visits with Progyny providers
-

Covered Services do NOT include:

- All Services for non-participant gestational carriers
- Services and supplies furnished by an Out-of-Network Provider or not listed as covered in the Progyny Member Guide
- Home ovulation prediction kits
- Treatments considered experimental by the American Society of Reproductive Medicine
- Ancillary medications such as antibiotics

Expenses for Fertility Services do not accumulate toward the Annual Out-of-Pocket Maximum. Select services for Fertility are administered through Progyny.

6.4 ADDITIONAL-COST TIER SERVICES

Coverage for certain Additional-Cost Tier Services must be Prior Authorized and is provided as shown in the Benefit Summary. The Deductible and Copayment for these procedures **do not** apply to your Out-of-Pocket Maximum. See section 4.4 for additional information on Prior Authorization.

The Additional-Cost Tier does not apply to Covered Services related to cancer diagnosis and treatment or to tissue injuries resulting from an external force which require immediate repair.

Additional-Cost Tier Covered Services:

- Upper gastrointestinal endoscopy
- High tech imaging services: MRI, MRA, MRS, CT, CTA, PET and SPECT (including nuclear imaging)
- Spine procedures
- Spine injections for pain
- Hip replacement
- Hip resurfacing
- Knee arthroscopy
- Knee replacement
- Knee resurfacing
- Shoulder arthroscopy
- Bariatric surgery
- Sinus surgery
- Morton's neuroma
- Hammertoe surgery
- Bunionectomy

6.5 GENETIC TESTING AND COUNSELING SERVICES

Genetic testing and counseling are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature. Select genetic testing requires Prior Authorization, for more information see section 4.4.
All Direct-to-Consumer genetic tests are considered investigational and are not covered.

6.6 GENE AND ADOPTIVE CELLULAR THERAPY

Gene and Adoptive Cellular Therapies are techniques that replace or modify a person's genes or cells to treat or cure some cancers and genetic diseases. Coverage is provided for Gene and/or Adoptive Cellular Therapy for Medically Necessary infusion benefits, as shown in the Benefit Summary.

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

7. EXCLUSIONS

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

General Exclusions:

We do not cover Services and supplies which:

- Are not provided;
- Are provided without charge or for which you would not be required to pay if you did not have this coverage;
- Are received before the Effective Date of Coverage;
- Are not a Covered Service or relate to complications resulting from a non-covered service;
- Are not furnished by a Qualified Practitioner or Qualified Treatment Facility;
- Are provided by or payable under any health plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law;
- Are provided while you are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies, except to the extent provided by 38 U. S. C. § 1729 as it relates to non-military Services provided at a Veterans Administration Hospital or facility;
- Are provided while in the custody of any law enforcement authorities or while incarcerated, except as provided in section 4.3;
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos, books, and educational programs to which drivers are referred by the judicial system and volunteer mutual support groups;
- Are provided to yield primarily educational outcomes, unless Medically Necessary or as otherwise covered under the Preventive Services benefit described in section 4.1. An outcome is "primarily educational" if the outcome's fundamental, first, or principal character is to provide you with enduring knowledge, skill, or competence through a process of repetitive positive reinforcement over an extended length of time. An outcome is "enduring" if long-lasting or permanent.
- Are performed in association with a Service that is not covered under this Plan, except Emergency Services;
- Are provided for any injury or illness that is sustained by a PEBB Member or a Family Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the PEBB Member or Family Member. This exclusion also applies to injuries and illnesses that are the subject of a claim settlement or disposition agreement under a Workers' Compensation Act or similar law. This exclusion does not apply to Participants who are exempt under any Workers' Compensation Act or similar law;

- Are payable under any automobile medical, personal injury protection (PIP), automobile no-fault, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance makes benefits or Services available to you, whether or not you make application for such benefits or Services, and whether or not you are refused payment for failure to satisfy any term of such coverage. If such coverage is required by law and you unlawfully fail to obtain it, benefits will be deemed to have been payable to the extent of that requirement. This exclusion also applies to charges applied to the deductibles of such contract or insurance. Any benefits or Services provided under this Plan that are subject to this exclusion are provided solely to assist you and such assistance does not waive the Plan's right to reimbursement or subrogation as specified in section 8.2. This exclusion also applies to Services and supplies after you have received proceeds from a settlement as specified in section 8.2.3;
- Are provided in a facility that specializes in treatment of developmental disabilities, except as provided in section 5.5.2;
- Are provided for treatment or testing required by a third party or court of law which is not Medically Necessary;
- Are Investigational;
- Are determined by Providence Health Plan not to be Medically Necessary for diagnosis and treatment of an injury or illness;
- Have not been Prior Authorized as required by this Plan; and
- Relate to any condition determined by Providence Health Plan to have been sustained as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Participant requiring Services, whether or not such Participant is charged or convicted of a crime on account of such illegal engagement or act (for purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony or misdemeanor under applicable law if such Participant is convicted for the conduct). Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or mental health condition). This exclusion does not apply to Mental Health or Substance Use Disorder Services;

The Plan does not cover:

- Charges that are in excess of the Usual, Customary and Reasonable (UCR) charges;
- Custodial Care;
- Transplants, except as described in section 6.1;
- Wart removal or treatment, except for plantar and sexually transmitted warts;
- Wrist ganglion cyst surgery;
- Services for Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices and Durable Medical Equipment (DME), except as described in section 5.9;

- Charges for Services that are primarily and customarily used for a non-medical purpose or used for home modifications, environmental control, or enhancements (whether or not prescribed by a physician) including, but not limited to, air conditioners, air purifiers, vacuum cleaners, motorized transportation equipment, escalators, elevators, tanning beds, ramps, waterbeds, hypoallergenic mattresses, cervical pillows, swimming pools, whirlpools, spas, exercise equipment, gravity lumbar reduction chairs, home blood pressure kits, personal computers and related equipment or other similar items or equipment;
- Physical therapy and rehabilitative Services, except as provided in section 5.4.3 and 5.10.12;
- Telephone visits by a physician or environment intervention or consultation by telephone for which a charge is made to the patient.
- Get acquainted visits without physical assessment or diagnostic or therapeutic intervention provided and treatment sessions by computer Internet service;
- Missed appointments;
- Non-emergency medical transportation;
- Allergy shots and allergy serums, except as provided in section 5.10.1;
- Services for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas;
- Transportation or travel time, food, lodging accommodations and communication expenses except as provided in sections 4.5 and with Providence Health Plan's Prior Authorization;
- Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
- Biofeedback, except as provided in section 5.10.20;
- Thermography;
- Homeopathic procedures;
- Comprehensive digestive stool analysis, cytotoxic food allergy test, dark-field examination for toxicity or parasites, EAV and electronic tests for diagnosis and allergy, fecal transient and retention time, Henshaw test, intestinal permeability, Loomis 24-hour urine nutrient/enzyme analysis, melatonin biorhythm challenge, salivary caffeine clearance, sulfate/creatinine ratio, urinary sodium benzoate, urine/saliva pH, tryptophan load test, and zinc tolerance test;
- Chiropractic manipulation and acupuncture, except as provided in sections 5.10.15 and 5.10.16;
- Light therapy for seasonal affective disorder, including equipment;
- Any vitamins, dietary supplements, and other non-prescription supplements;
- Services for genetic testing are excluded, except as provided in section 6.5 and 5.11;
- Services to modify the use of tobacco and nicotine, except as provided in section 5.2.12;
- Cosmetic Services including supplies and drugs not considered Medically Necessary;
- Services required solely for obtaining insurance, employment, licensure (except as specified in section 5.2.1) or school admission; Services solely for the purpose of participation in camps, sports activities or recreational programs, travel, or passport requirements for foreign travel;
- Non-sterile examination gloves;

- Sales taxes, handling fees and similar surcharges, as explained in the definition of UCR;
- Air ambulance transportation for non-emergency situations is not covered, except as provided in section 5.7.2;
- Treatments that do not meet the national standards for Mental Health/Substance Use Disorder professional practice;
- Services provided under a court order or as a condition of parole or probation or instead of incarceration, unless Medically Necessary;
- Personal growth Services such as assertiveness training or consciousness raising;
- School counseling and support Services, peer support Services, tutor and mentor Services; independent living Services, household management training, and wraparound services that are provided by a school or halfway house and received as part of an educational or training program;
- Recreation services, therapeutic foster care, wraparound Services; emergency aid for household items and expenses; Services to improve economic stability, and interpretation Services;
- Evaluation or treatment for education, professional training, employment investigations, and fitness for duty evaluations;
- Community Care Facilities that provide twenty-four (24) hour non-medical residential care;
- Counseling related to family, marriage, sex and career including, but not limited to, counseling for adoption, custody, family planning or pregnancy, This exclusion does not apply to Mental Health or Substance Use Disorders;
- Neurological Services and tests including, but not limited to EEGs; PET, CT and MRI imaging Services; and beam scans (except as provided in section 5.10.3);
- Except for gender identity disorder, services related to the treatment of sexual disorders, dysfunctions or addiction;
- Vocational, pastoral or spiritual counseling;
- Viscosupplementation (i.e., hyaluronic acid/hyaluronan injection);
- All Direct-to-Consumer testing products; and
- Dance, poetry, music or art therapy, except as part of an approved treatment program.

Exclusions that apply to Provider Services:

The following Services if they are provided by an Out-of-Network Provider:

- E-mail Visit Services (see section 5.1.2); Bariatric Surgery and related Services (see section 5.1.3);
- Tobacco Use Cessation Services (see section 5.2.10);
- Prescription Drug Services (see section 5.11);
- Human Organ/Tissue Transplants (see section 6.1); and
- Temporomandibular Joint (TMJ) Services (see section 6.2.1);
- Services of homeopaths; faith healers; or lay, unlicensed direct entry, and professional midwives; and
- Services of any unlicensed providers.

Exclusions that apply to Reproductive Services:

- Treatment related to sexual disorders or dysfunctions regardless of gender (for coverage of medications to treat sexual dysfunction, see your Benefit Summary), except as provided in section 5.10.23. This exclusion does not apply to Mental Health Covered Services;
- Male condoms and other over-the-counter birth control products for men;
- Home births and all related Services, except Services provided by a Qualified Provider; and
- Services of Licensed Direct Entry Midwives (LDEM) except as described in OAR 332-025-0021 and following our receipt of the LDEM disclosure statement.

Exclusions that apply to Vision Services:

- Surgical procedures which alter the refractive character of the eye, including, but not limited to laser eye surgery, radial keratotomy, myopic keratomileusis and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia, hyperopia or astigmatism;
- Services for routine eye exams and vision care, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in section 5.9.2; and
- Vision training.

Exclusions that apply to Dental Services:

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

Exclusions that apply to Foot Care Services:

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

Exclusions that apply to Prescription Drugs, Medicines and Devices:

- Outpatient prescription drugs, medicines and devices except as provided in sections 5.2.5, 5.9, and 5.11, and
- Any drug, medicine, or device that does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Pre-market Approval, or 510K.

8. CLAIMS ADMINISTRATION

This section explains how Providence Health Plan treats various matters having to do with administering your benefits and claims, including situations that may arise in which your health care expenses are the responsibility of a source other than Providence Health Plan.

8.1 SUBMITTING CLAIMS

All Medical Home Providers, In-Network Providers and many Out-of-Network Providers will bill Providence Health Plan for you. You may receive a bill for information purposes only indicating your insurance has been billed. In order to ensure the timely processing of claims, you are encouraged to submit a claim for treatment within 60 days of the date of Service. The Plan will not pay claims received more than 12 months after the date of Service. However, exceptions will be made if we receive documentation of your legal incapacitation. The Plan will pay a covered expense to the provider, the Participant, or jointly to both. If the Plan mistakenly makes a payment to which a Participant is not entitled, the Plan may recover the payment.

In some instances, the Out-of-Network provider will not bill Providence Health Plan for you. When this occurs, you will be responsible for paying the bill for your services directly to that health care provider. The Plan will reimburse you for Covered Services according to the terms of the Plan.

To request reimbursement, obtain an itemized receipt from the provider's office. You itemized receipt must include the following:

- Date of Service
- Member/patient name
- Member/patient date of birth
- Name, address, tax identification number, national provider index (NPI) number, and the address of the provider or facility
- Diagnosis and procedure codes(s)
- Amount charged for each service
- Amount paid for each service

Submit the itemized receipt to the addresses listed below. You may also submit a claim via your My Collective portal at https://providencehealthplan.pebb.collectivehealth.com.

Claims should be submitted to Collective Health at:

Attention: Member Claims
Collective Health
1557 W Innovation Way, Suite 300
Lehi, UT 84043

For claim questions, please call (855) 284-1368

Elective abortion claims should be submitted to:

Progyny
Attention: Claims
505 South Lenola Rd
Suite 231
Moorestown, NJ 08057
833-233-1070 (M-F 8:00AM – 4:30PM Pacific Time)

Explanation of Benefits (EOB)

You will receive an EOB from Collective Health after your claim is processed. An EOB is not a bill. An EOB explains how Collective Health has processed your claim and it will assist you in determining your financial responsibility for the Services shown on the EOB. Deductible, Copayment and Coinsurance amounts, Services or amounts not covered and general information about Collective Health's processing of your claim are explained on the EOB.

Time Frames for Processing Claims

If your claim is denied under the Plan, Collective Health will send an EOB to you with an explanation of the denial within 30 days after your claim is received. If Collective Health needs additional time to process your claim for reasons beyond their control, you will be sent a notice of delay explaining those reasons within 30 days after your claim is received. Collective Health will then complete the processing and send an EOB to you within 45 days after your claim is received. If Collective Health needs additional information from you to complete the processing of your claim, the notice of delay will describe the information needed and you will have 45 days to submit the additional information. Once Collective Health receives the additional information, they will complete the processing of the claim within 30 days.

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

- **For Prior Authorization of Services that do not involve urgent medical conditions:** Providence Health Plan will notify your provider or you of their decision within 2 business days after the Prior Authorization request is received. If additional information is needed to process the request, Providence Health Plan will provide written notice to the Member and the provider within two business days of receiving the Prior Authorization request. The Member and the provider will have 15 days to submit the additional information. Within two business days of receipt of the additional information, Providence Health Plan will complete its review and provide written notice of its decision to the Member and the provider. If the information is not received within 15 days, the request will be denied.

- **For Prior Authorization of Services that involve urgent medical conditions:** Providence Health Plan will notify your provider or you of their decision within 72 hours after the Prior Authorization request is received. If Providence Health Plan needs additional information to complete their review, they will notify the requesting provider or you within 24 hours after the request is received. The requesting provider or you will then have 48 hours to submit the additional information. Providence Health Plan will then complete their review and notify the requesting provider or you of their decision by the earlier of, (a) 48 hours after the additional information is received or, (b) if no additional information is provided, 48 hours after the additional information was due.
- **For Formulary exceptions:** For standard requests, Providence Health Plan will notify your provider or you of its decision within 72 hours after receipt of the request. For expedited requests, Providence Health Plan will notify your provider or you of its decision within 24 hours after receipt of the request. To qualify for expedited review, the request must be based upon exigent circumstances.

Claims Involving Concurrent Care Decisions

If an ongoing course of treatment for you has been approved by Providence Health Plan and they then determine through their medical cost management procedures to reduce or terminate that course of treatment, you will be provided with advance notice of that decision. You may request a reconsideration of that decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. Providence Health Plan will then notify you of their reconsideration decision within 24 hours after your request is received.

8.1.1 Right of Recovery

Providence Health Plan, on behalf of this Plan, has the right, upon demand, to recover from a recipient the value of any benefit or claim payment that exceeded the benefits available under this Plan. This right of recovery applies to any excess benefit, including (but not limited to) benefits obtained through fraud, error, or duplicate coverage relating to any Member. If timely repayment is not made to the Plan, Providence Health Plan is authorized by PEBB deduct the value of the excess benefit from any future benefit that otherwise would have been available to the affected Member(s) under this Plan. Providence Health Plan, on behalf of the Plan, has the right to recover pharmacy overpayments directly from you or your family member.

8.2 THIRD-PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as “Participant(s)”) or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to crime victim restitution funds, civil restitution funds, no-fault restitution funds (including vaccine injury compensation funds), uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party, any medical, applicable disability, or other benefit payments, and school insurance coverage (collectively “Coverage”).

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Participant(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of Plan Document and Summary Plan Description 59 collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in

trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Participant(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other guarantor on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a responsible third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any of the following:
    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - School insurance coverage

The Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources.
The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and

function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan. Additionally, the Participant shall indemnify the Plan against any of the Participant's attorney's fees, costs, or other expenses related to the Participant's recovery for which the Plan becomes responsible by any means other than the Plan's explicit written consent.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury or disability.

Participant is a Trustee Over Plan Assets

Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or Accident. By virtue of this status, the Participant understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in

an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Participant(s) ("Incurred") prior to the liable party being released from liability. The Participant's/Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care Incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.

Excess Insurance

Except as outlined in the "Effect on Benefits" provision in regard to any Other Plan, if at the time of Injury, Illness or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other guarantor on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a responsible third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any of the following:
    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - School insurance coverage

Separation of Funds

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations

It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Illness, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
7. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
9. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
10. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status

In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

8.3 COORDINATION OF BENEFITS (COB)

This Coordination of Benefits (COB) section applies when you or a Family Member has health care coverage under more than one Plan. The term "Plan" is defined below for the purposes of this COB section. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total Allowable expense.

If you have more than one insurance plan, obtaining Services under this Plan may be affected. Please contact Collective Health Member Advocates at 855-284-1368for more information or assistance.

8.3.1 Definitions Relating to COB

Plan

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

1. Plan includes: group and individual health insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law and group and individual insurance contracts and Subscriber contracts that pay or reimburse for the cost of dental care.
2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

This Plan

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

The order of benefit determination rules listed in section 8.3.2 determine whether this Plan is a Primary Plan or Secondary Plan when you or a Family Member has health care coverage under more than one Plan.

When this Plan is primary, Providence Health Plan determines payment for benefits first before those of any other plan without considering any other plan's benefits. When this Plan is secondary, Providence Health Plan determines benefits after those of another plan and may reduce the benefits paid so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense

Allowable expense means a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any plan covering you or a Family Member. When a plan provides benefits in the form of Services, the reasonable cash value of each Service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any plan covering you or a Family Member is not an Allowable expense.

In addition, any expense for which a provider by law or in accordance with a contractual agreement is prohibited from charging is not an Allowable expense.

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

- The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the plans provides coverage for private hospital room expenses.
- If the Member is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
- If the Member is covered by two or more plans that provide benefits or Services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
- If the Member is covered by one plan that calculates its benefits or Services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or Services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all plans. However, if the provider has contracted with the Secondary plan to provide the benefit or Service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
- The amount of any benefit reduction by the Primary plan the Member have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Closed panel plan

A Closed panel plan is a Plan that provides health care benefits to Members primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial parent

A Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the Dependent child resides more than one half of the Calendar Year excluding any temporary visitation.

8.3.2 Priority between Plans

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

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan. If the Primary plan is a Closed panel plan and the secondary plan is not a Closed panel plan, the Secondary plan shall pay or provide benefits as if it were the Primary plan when a covered person uses a non-panel provider, except for Emergency Services or authorized referrals that are paid or provided by the Primary plan.
    1. Except as provided in Paragraph (2) below, a Plan that does not contain a COB provision that is consistent with the State of Oregon's COB regulations is

always primary unless the provisions of both plans state that the complying Plan is primary.

2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network benefits.

B. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

C. Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent.** The Plan that covers a Family Member other than as a Dependent, for example as a PEBB Member, is the Primary plan and the Plan that covers the Family Member as a Dependent is the Secondary plan. However, if the Family Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the Family Member as a Dependent; and primary to the plan covering the Family Member as other than a Dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the Plan covering the Family Member as an employee, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

2. **Dependent Child Covered Under More Than One Plan.** Unless there is a court decree stating otherwise, when a Family Member is a Dependent child covered by more than one Plan the order of benefits is determined as follows:

   a) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

      i. The Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary plan; or

      ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

   b) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

      i. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

      ii. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

      iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

iv. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the Dependent child are as follows:
    - The Plan covering the Custodial parent, first;
    - The Plan covering the spouse of the Custodial parent, second;
    - The Plan covering the non-custodial parent, third; and then
    - The Plan covering the spouse of the non-custodial parent, last.

c) For a Dependent child covered under more than one Plan of individuals who are not the parents of the Dependent child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the Dependent child.

d) For a Dependent child:

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

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

3. **PEBB Member or Retired or Laid-off Employee.** The Plan that covers a PEBB Member as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same PEBB Member as a retired or laid-off employee is the Secondary plan. The same would hold true if a PEBB Member is a Dependent of an active employee and that same Member is a Dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C(1) can determine the order of benefits.
4. **COBRA or State Continuation Coverage.** If a PEBB Member or Family Member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the Plan providing coverage as an employee, subscriber or retiree or as a Dependent of an employee, Subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C(1) can determine the order of benefits.
5. **Longer or Shorter Length of Coverage.** The Plan that covered the Member for the longer period of time is the Primary plan and the Plan that covered the Member for the shorter period of time is the Secondary plan.
6. **If the preceding rules do not determine the order of benefits,** the Allowable expenses shall be shared equally between the Plans meeting the definition of

Plan. In addition, this Plan will not pay more than would have paid had it been the Primary plan.

8.3.3 Effect on the Benefits of This Plan

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

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

8.3.4 Right to Receive and Release Necessary Information

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

8.3.5 Facility of Payment

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

8.3.6 COB Right of Recovery

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

8.4 NON–DUPLICATION OF COVERAGE

8.4.1 Coordination with Medicare

In all cases, coordination of benefits with Medicare will conform to federal statutes and regulations. Medicare means Title XVIII of the Social Security Act, as enacted or amended.

Medicare eligibility and how Providence Health Plan determines benefit limits under this Plan are affected by disability and employment status. Please contact Providence Health Plan Collective Health Member Advocates at (855) 284-1368 if you have questions.

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

9. PROBLEM RESOLUTION

9.1 INFORMAL PROBLEM RESOLUTION

All people who work with Providence Health Plan share responsibility for assuring Participant satisfaction. If you have a problem or concern about your coverage, including benefits or Services by In-Network Providers or payment for Services by Out-of-Network Providers, please ask for Collective Health's help. Your Collective Health Member Advocates are available to provide information and assistance. You may call Collective Health or meet with a representative at the phone number and address listed on your Membership ID Card. If you have special needs, such as a hearing impairment, Collective Health will make efforts to accommodate your requirements. Please contact Collective Health for assistance with whatever special needs you may have.

9.2 MEMBER GRIEVANCE AND APPEAL

Definitions:

Adverse Benefit Determination

An Adverse Benefit Determination means a:

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

Appeal

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

Authorized Representative

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

Concurrent Care

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

Grievance

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

- In writing, for an internal Appeal or an external review; or in writing or orally, for an expedited response or an expedited external review; or

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

9.2.1 Your Grievance and Appeal Rights

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

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

Request for Claim/Appeal File and Additional Information:

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

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

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

To the extent possible, Collective Health Member Advocates will resolve complaints filed by telephone at the point of service. We will acknowledge all non-urgent pre-service and post-service Grievance and Appeals within seven days of receipt and resolve within 30 days or sooner depending on the clinical urgency. Urgent medical conditions and concurrent care have different resolution timelines as noted below.

Urgent Medical Conditions: If you believe your health would be seriously harmed by waiting for Collective Health's decision on your Grievance or Appeal of a denied Prior Authorization request or Concurrent Care request, you may request an expedited review by calling a Collective Health Member Advocate at the number on the back of your medical ID card. If your Appeal is urgent, and qualifies for external review, you may request to have both your

internal and external Appeal expedited at the same time. You will be notified by phone and in writing if your case qualifies for an expedited review. If it does, Providence Health Plan will notify you of the decision within 72 hours of receiving your request.

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

9.2.2 Internal Grievance or Appeal

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

9.2.3 External Review

If you are not satisfied with the internal Grievance or Appeal decision and your Appeal involves (a) Medically Necessary treatment, (b) Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care, or (e) an exception to the Plan's prescription drug formulary, you may request an external review by an Independent Review Organization (IRO). Your request must be made within 180 days of the receipt of the internal Grievance or Appeal decision, or that internal decision will become final. If you agree, Providence Health Plan may waive the requirement that you exhaust the internal review process before beginning the External Review process. When the External Review process is begun, an IRO will be assigned to the case, and we will forward complete documentation regarding the case to the IRO.

If you request an External Review, you must agree to authorize release of medical records needed by the IRO and submit any additional information to the IRO no later than five days after the appointment of the IRO, or 24 hours in cases of expedited review. The IRO is entirely independent of Providence Health Plan. There is no cost to you to obtain an External Review decision within three days from the expedited review and within 30 days when not expedited. The IRO will notify you and Providence Health Plan of its decision. **The Plan and Providence Health Plan agree to comply with the IRO decision when the decision involves (a) Medically Necessary treatment; (b) Investigational treatment; (c) an active course of treatment for purposes of continuity of care; (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care; or (e) an exception to the Plan's prescription drug formulary.**

The Plan pays all costs for the handling of External Review cases, and Providence Health Plan administers these provisions in accordance with the insurance laws and regulations of the State of Oregon. By electing to submit your Appeal to an IRO, you are also agreeing to be bound by and to comply with the IRO decision regarding your Appeal in lieu of appealing to a state of federal court. **If the Plan and Providence Health Plan do not comply with the IRO decision, you have the right to sue under applicable Oregon law.**

9.2.4 Information Available Upon Request

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

9.2.5 How to Submit Grievances or Appeals and Request Appeal Documents

Your In-Network Provider will often appeal a prior authorization decision on your behalf, or you may submit an appeal yourself. Instructions for how to submit an appeal will be included in the initial determination letter.

If the services are rendered in Oregon or Wahkiakum, Skamania, Cowlitz, Clark, or Klickitat county in Washington, you may send an appeal for prior authorization denial to American Health Holdings by fax to 866-881-9643 or by email to ahh_appeals@ahhinc.com or by mail:

American Health Holdings Appeals Dept.
7400 West Campus Road, F-510
New Albany, OH 43054

If the services are rendered in the rest of the United States, you may send an appeal for prior authorization denial to Cigna by mail:

Cigna Healthcare
Attn: Appeals
P.O. Box 188062
Chattanooga, TN 37422-8062

If you wish to appeal a non-clinical benefit determination, you may contact Collective Health Member Advocates at (855) 284-1368. If you are hearing impaired and use a Teletype (TTY) Device, please call Providence Health Plan's TTY line at 711. Written Grievances or Appeals or requests for External Review should be sent to:

ATTN: Member Appeals Team
Collective Health
1557 W Innovation Way, Suite 300
Lehi, UT 84043

You may fax your Grievance or Appeal or requests for External Review to 888-972-8074.

9.2.6 Assistance from the PEBB Benefit Manager

You may contact the PEBB Benefit Manager at 503-373-1102.

9.2.7 Assistance from the Oregon Division of Financial Regulation

You also have the right to file a complaint and seek assistance from the Oregon Division of Financial Regulation at:

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

503-947-7984
888-877-4894 (toll-free)
503-378-4351 (fax)
https://dfr.oregon.gov (website)

Please note that your enrolled dependents also have the right to Grievance and Appeal as described here.

10. TERMINATION OF MEMBER COVERAGE

10.1 TERMINATION EVENTS

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

10.2 TERMINATION AND RECISSION OF COVERAGE DUE TO FRAUD OR ABUSE

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

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

10.3 NON-LIABILITY AFTER TERMINATION

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

10.4 PROOF OF PRIOR COVERAGE

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

11. CONTINUATION OF MEDICAL BENEFITS (COBRA)

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

11.1 COBRA QUALIFYING EVENTS

11.1.1 PEBB Member's COBRA Continuation Coverage

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

11.1.2 Spouse's or Domestic Partner's COBRA Continuation Coverage

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

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

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

11.1.3 Dependent's COBRA Continuation Coverage

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

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

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

11.2 COBRA NOTICE REQUIREMENTS

A Family Member's coverage ends on the last day of the month in which a divorce or termination of domestic partnership occurs or a child loses dependent status under the Plan. Under COBRA, you or your Family Member has the responsibility to notify PEBB if one of these events occurs. Written notice must be given no later than 60 days after the loss of

coverage has occurred, or the qualifying event, whichever is later. Oral notice is not binding until confirmed in writing. If notice is not timely given, continuation coverage will not be available.

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

11.3 COBRA ADMINISTRATION SERVICES

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

11.4 TYPE OF COBRA CONTINUATION COVERAGE

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

11.5 COBRA ELECTION RIGHTS

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

11.6 COBRA PREMIUMS

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

The premium for COBRA continuation coverage may fluctuate following the groups annual renewal process.

11.7 LENGTH OF COBRA CONTINUATION COVERAGE

11.7.1 18-Month Continuation Period

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

11.7.2 29-Month Continuation Period

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

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

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

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

11.7.3 36-Month Continuation Period

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

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

11.7.4 Extension of COBRA Continuation Period

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

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

11.7.5 Extension of Coverage for a Spouse or Oregon Registered Certificate Domestic Partner

If a surviving, divorced, or Oregon Registered Certificate Domestic Partner of a PEBB Member is at least 55 years old at the time of death or the dissolution of the marriage, or partnership she or he may be eligible to continue coverage under this Plan. This State of

Oregon provision for continuation of coverage will terminate upon the earliest of any of the following:

- The failure to pay premiums when due, including any grace period;
- The date that this Plan is terminated;
- The date on which the surviving, divorced or legally separated spouse becomes covered under any other group health plan, including spousal coverage because of remarriage; or
- The date on which the surviving, divorced or legally separated spouse becomes eligible for federal Medicare coverage.

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

11.8 THE TRADE ACT OF 2002

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

11.9 WHEN COBRA CONTINUATION COVERAGE ENDS

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

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

12. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

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

12.1 DEFINITIONS

For purposes of this section, the following definitions shall apply:

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

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

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

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

A "Qualified Medical Child Support Order" or "QMCSO" means an Order:

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

"Procedures" means the Qualified Medical Child Support Order procedures as prescribed in this section.

"Designated Representative" means a representative designated by an Alternate Recipient to receive copies of notices that are sent to the Alternate Recipient with respect to an Order.

12.2 NOTICE UPON RECEIPT OF ORDER

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

12.3 NOTICE OF DETERMINATION

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

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

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

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

12.4 ENROLLMENT OF ALTERNATE RECIPIENT

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

12.5 COST OF COVERAGE

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

12.6 REIMBURSEMENT OF PLAN EXPENSES

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

12.7 STATUS OF ALTERNATE RECIPIENT

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

12.8 TREATMENT OF NATIONAL MEDICAL SUPPORT NOTICE

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

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

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

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

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

13. GENERAL PROVISIONS

13.1 DUPLICATING PROVISIONS

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

13.2 FAILURE TO PROVIDE INFORMATION

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

13.3 MEMBER RESPONSIBILITY

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

13.4 MEMBERSHIP ID CARD

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

- Your Member identification number and group number
- Your particular health plan
- Important phone numbers

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

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

- Visit your health care provider or facility.
- Call for Mental Health/Substance Use Disorder customer service.
- Call or correspond with Collective Health Member Advocates.
- Call Galileo nurse advice line.
- Visit your pharmacy for prescriptions.
- Receive Immediate, Urgent or Emergency Care Services.

13.5 NON-TRANSFERABILITY OF BENEFITS

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

13.6 NON-WAIVER

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

13.7 NO RECOURSE FOR ACTS OF PROVIDERS

The Hospitals, Skilled Nursing Facilities, physicians and other persons or organizations providing Services to you do so as independent contractors. Neither PEBB nor Providence Health Plan is liable for any claim or demand due to damages arising out of or in any manner connected with any injuries suffered by you while receiving such Services.

13.8 NOTICE

Any notice required of PEBB or Providence Health Plan under this Plan shall be deemed to be sufficient if mailed to the Participant at the address appearing on the records of Providence Health Plan. Any notice required of you shall be deemed sufficient if mailed to the principal office of Collective Health at 1557 W Innovation Way, Lehi, UT 84043.

13.9 NOTICE REQUIRED FOR REIMBURSEMENT AND PAYMENT OF CLAIM

Plan payments for most Services are made directly to the providers of Services. Except as otherwise specifically provided in this Plan, if you are billed directly and pay for benefits which are covered by this Plan, reimbursement from the Plan will be made only upon your written notice to Providence Health Plan of the payment. Payment will be made to the Participant, subject to written notice of claim, or, if deceased, to the Participant's estate, unless payment to other parties is authorized in writing by you. See section 8.1 regarding timely submission of claims.

13.10 PHYSICAL EXAMINATION AND AUTOPSY

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

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

13.11 PROFESSIONAL REVIEW AND RIGHT TO EXAMINE RECORDS

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

All Participants, for purposes other than utilization review, quality assurance and peer review, may be required to authorize any provider to give and discuss with Providence Health Plan any information relating to any condition for which benefits are claimed under this Plan. Providence Health Plan may transfer this information between providers or other organizations who are treating you or performing a Service on behalf of Providence Health Plan. If you do not consent to the release of records or to discussions with providers,

Providence Health Plan will be unable to determine the proper payment of any benefits and will deny the claims accordingly. Consent to the release of records and discussion with providers is a condition of payment of any benefits. Neither the consent to, nor the actual examination of the records or discussion with providers will constitute a guarantee of payment.

13.12 SEVERABILITY

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

13.13 SUGGESTIONS

You are encouraged to make suggestions to Providence Health Plan. Suggestions may be oral or written and should be directed to Collective Health Member Advocates at 855-284-1368.

13.14 RIGHT OF RECOVERY

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

13.15 WORKERS' COMPENSATION INSURANCE

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

13.16 NO GUARANTEE OF EMPLOYMENT

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

13.17 REQUIRED INFORMATION TO BE FURNISHED

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

13.18 PAYMENT OF BENEFITS TO PERSONS UNDER LEGAL DISABILITY

Whenever any person entitled to payments under the Plan is determined to be a minor or under other legal disability or otherwise incapacitated in any way so as to be unable to manage such person's financial affairs, or otherwise incapable of giving a valid receipt and discharge for any payment, the following provision shall apply. Providence Health Plan, in its discretion, may direct that all or any portion of such payments be made (i) to such person,

(ii) to such person's legal guardian or conservator, or (iii) to such person's spouse or to any other person, in any manner which Providence Health Plan considers advisable, to be expended for the person's benefit. Providence Health Plan's decision will, in each case, be final and binding upon all persons. Any payment made pursuant to the power herein conferred shall operate as a complete discharge of the obligations under the Plan in respect thereof by PEBB and Providence Health Plan.

13.19 STATE MEDICAID BENEFITS RIGHTS

Notwithstanding any provision of the Plan to the contrary:

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

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

13.20 VETERAN'S RIGHTS

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

1. A Participant who takes unpaid military leave, or who separates from employment to perform services in the armed forces or another uniformed service, can elect continued coverage under the Plan (including coverage for the Eligible Family Dependents). The applicable Contribution for such coverage, and the Contribution payment procedures, shall be as generally prescribed for COBRA continuation coverage in section 11. Effective for elections made on or after December 10, 2004, the period for such continuation coverage shall extend until the earlier of:
    a) The end of the 24-month period beginning on the date on which the Participant's absence for the purpose of performing military service begins; or
    b) The date the Participant fails to timely return to employment or reapply for a position covered by PEBB upon the completion of such military service.

13.21 CONTROLLING STATE LAW

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

13.22 LIMITATIONS ON PROVISIONS

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

13.23 GENDER AND NUMBER

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

13.24 HEADINGS

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

13.25 CONFLICTS OF PROVISIONS

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

13.26 LEGAL ACTION

No civil action may be brought under state or federal law to recover Plan benefits until receipt of a final decision under the Member Grievance and Appeal process specified in section 9 of this Member Handbook.

13.27 PROTECTED HEALTH INFORMATION

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

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

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

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

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

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

(f) PEBB shall allow Participants to amend their PHI in accordance with the privacy regulations of HIPAA.
(g) PEBB shall provide Participants with an accounting of its disclosure of their PHI in accordance with the privacy regulations of HIPAA.
(h) PEBB shall make its internal practices, books and records relating to the use and disclosure of PHI received from Providence Health Plan available to the Secretary of the Department of Health and Human Services in accordance with the privacy regulations of HIPAA.
(i) PEBB shall, if feasible, return or destroy all PHI received from Providence Health Plan and retain no copies of such information when no longer needed for the purpose for which such information was received except that, if such return or destruction is not feasible, PEBB shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
(j) PEBB shall provide for adequate separation between PEBB and Providence Health Plan with regard to the use and disclosure of PHI. For that purpose, access to PHI shall be limited to the following employees or classes of employees of PEBB or designated individuals:
    1. Plan Design Manager;
    2. Director of Operations;
    3. PEBB's Designated Consultants; and
    4. Internal Auditors, including representatives of the Oregon Secretary of State or Department of Justice, when performing Health Plan Audits.

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

Security: In accordance with the security standards of HIPAA, PEBB shall:
(a) Implement administrative, physical, and technical safeguards that protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
(b) Ensure that the separation of access to PHI that is specified in paragraph (j) above is supported by appropriate security measures;
(c) Ensure that any agent or subcontractor to whom PEBB provides PHI agrees to implement appropriate security measures to protect such information; and
(d) Report to the Plan any security incident regarding PHI of which PEBB becomes aware.

14. DEFINITIONS

The following are definitions of important terms used in this Plan:

Adverse Benefit Determination
See section 9.

Alternative Care Provider
Alternative Care Provider means a naturopath, chiropractor, acupuncturist or massage therapist who is professionally licensed by the appropriate governmental agency to diagnose or treat an injury or illness and who provides Covered Services within the scope of that license.

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

Annual
Annual means once per Calendar Year.

Appeal
See section 9.

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

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

Authorized Representative
See section 9.

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

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

Cochlear Implant
See section 5.10.18.

Coinsurance
Coinsurance means the dollar amount that you are responsible to pay to a health care provider for a Covered Service after your claim has been processed by Providence Health

Plan. Your Coinsurance for a Covered Service is shown in the Benefit Summary and is a percentage of the charges for the Covered Service.

Confinement

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

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

Contribution

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

Copayment

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

Cosmetic Services

Cosmetic Services means Services or surgery performed to reshape normal structures of the body in order to improve your appearance or self-esteem.

Covered Service

Covered Service means a Service that is:

1. Listed as a benefit in the Benefit Summary and in the Covered Services section of this Member Handbook;
2. Medically Necessary;
3. Not listed as an Exclusion or Limitation in the Benefit Summary or in the relevant sections of this Member Handbook; and
4. Provided to you while you are a Participant and eligible for the Service under this Plan.

Custodial Care

Custodial Care means Services that:

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

Such Services will still be considered Custodial Care even if:

1. You are under the care of a physician;
2. The Services are prescribed by an In-Network Provider;
3. The Services function to support or maintain your condition; or
4. The Services are being provided by a registered nurse or licensed practical nurse.

Deductible

See section 4.10.1.

Diagnostic Breast Examination

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

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

Durable Medical Equipment (DME)

Durable Medical Equipment means equipment that must:

1. Be able to withstand repeated use;
2. Be primarily and customarily used to serve a medical purpose; and
3. Not be generally useful to a person except for the treatment of an injury or illness.

E-mail Visit

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

Effective Date of Coverage

Effective Date of Coverage means the date upon which coverage under this Plan commences for a PEBB Member, which shall be: The first day of the month after which a PEBB Member is properly enrolled.

Emergency Medical Condition

See section 5.7.

Emergency Medical Screening Exams

See section 5.7.

Emergency Services

See section 5.7.

Essential Health Benefits

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

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

Facial Electrolysis
Facial Electrolysis is the permanent removal of facial hair, including the hair root, with the use of an electronic device.

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

Gender Affirming Treatment
Gender-affirming treatment means a procedure, service, drug, device or product that a physical or behavioral health care provider prescribes to treat an individual for incongruence between the individual's gender identity and the individual's sex assignment at birth.

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

Global Fee
See section 6.1.3.

Grievance
See section 9.

Health Benefit Plan
Health Benefit Plan means any hospital or medical expense policy or certificate issued by a health care service contractor or health maintenance organization and any plan provided by a multiple employer welfare arrangement or other benefit arrangement defined in ERISA.

Hearing Aid
See section 5.10.18.

Hearing Assistance Technology
See section 5.10.18.

HIPAA
HIPAA means the Health Insurance Portability and Accountability Act of 1996.

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

Hospital
Hospital means an institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;
2. Has a physician or surgeon in regular attendance;
3. Provides continuous 24-hour-a-day nursing Services;

4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
5. Is legally operated in the jurisdiction where located; and
6. Has surgical facilities on its premises or has a contractual agreement for surgical Services with an institution having a valid license to provide such surgical Services.

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

Independent Freestanding Emergency Department
Independent Freestanding Emergency Department means a health care facility that provides Emergency Services and is geographically separate and distinct and licensed separately from a Hospital under applicable State law. See Section 5.7.1.

In Network
The level of benefits specified in the Benefit Summary or covered Services provided by a provider participating in the Providence Choice Plan Network.

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

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

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

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

Maximum Cost Share
See section 4.10.3.

Medical Home

Medical Home means one of the special clinics located within the Providence Choice Network that has agreed to provide Services and coordinate care for Members under this Plan.

Medically Necessary

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

The criteria are based on the following principles:

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

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

Member

Member means principal subscriber or each eligible family dependent who is properly enrolled in and entitled to Services under the provisions of this Plan. See Participant.

Member Handbook

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

Mental Health

Providence Health Plan has adopted the current version of the International Classification of Diseases, Clinical Modification (ICD-10-CM) and the current version of the Diagnostic and Statistical Manual (DSM 5-TR) as the standard for determining what constitutes medical and surgical Services and Mental Health and Substance Use Disorder Services.

Mental Health benefits are defined as benefits designed to treat Mental Health conditions that fall under any of the diagnostic categories listed in the most current version of the DSM or in the mental, behavioral, and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the ICD.

Open Enrollment Period

Open Enrollment Period means the period determined by PEBB during which PEBB Members may enroll themselves, an eligible spouse, domestic partner, and dependent children in this Plan for the upcoming Plan Year, subject to the terms and provisions as found in the Oregon Administrative Rule Chapter 101 and PEBB Summary Plan Description.

Out of Network

The level of benefit specified in the Benefit Summary for Covered Services provided by an Out-of-Network provider.

Out-of-Network Provider

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

Out-Of-Pocket Maximum

See section 4.10.2.

Outpatient Surgical Facility

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

Participant

Participant means a PEBB Member or an eligible spouse, domestic partner, or dependent child who is properly enrolled in this Plan, and entitled to Services under this Plan.

Participating Pharmacy

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

1. Retail: A Participating Pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions.
2. Preferred Retail: A Participating Pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.

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

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

PEBB Member
PEBB Member means an active Oregon public employee, former employee, or legislatively approved individual who is eligible for enrollment in this Plan in accordance with the provisions specified in the PEBB Summary Plan Description and the Oregon Administrative Rules, Chapter 101.

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

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

Polycystic Ovary Syndrome (PCOS)
Polycystic Ovary Syndrome (PCOS) is a condition in which the ovaries produce an imbalance of reproductive hormones, which may disrupt ovulation or menstruation.

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

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

Note: Not all Qualified Practitioners are Primary Care Providers. To obtain a listing of Medical Home Primary Care Providers, please see the Provider Directory online at My Collective.

Prior Authorization
Prior Authorization or Prior Authorized means a request to Providence Health Plan by you or by a Qualified Practitioner regarding a proposed Service, for which prior approval is granted by Providence Health Plan. Prior Authorization review will determine if the proposed Service is eligible as a Covered Service or if an individual is a Participant at the time of the proposed Service. To facilitate our review of the Prior Authorization request, we may require additional information about the Member's condition and/or the Services requested. We may also

require that a Member receive further evaluation from a Qualified Practitioner of our choosing. Prior Authorization is subject to the terms and provisions of this Member Handbook. Prior Authorization is not a guarantee of benefit payment (e.g., if the Participant's coverage terminates before the Prior Authorized procedure is performed). See section 4.4 for more information.

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

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

Providence Choice Network
Providence Choice Network means the network of Medical Homes and In-Network Providers that have agreed to provide Covered Services for Members of this Plan.

Providence Health Plan
Providence Health Plan means the nonprofit corporation authorized as a health care service contractor in the states of Oregon with respect to this Plan.

Qualified Practitioner
Qualified Practitioner means a physician, Women's Health Care Provider, nurse practitioner, naturopath, clinical social worker, physician associate, psychologist, dentist, or other practitioner who is professionally licensed by the appropriate governmental agency to diagnose or treat an injury or illness and who provides Covered Services within the scope of that license.

Qualified Treatment Facility
Qualified Treatment Facility means a facility, institution or clinic duly licensed by the appropriate governmental agency, which is primarily established and operating within the lawful scope of its license.

Reconstructive Surgery
Reconstructive Surgery means surgery that restores features damaged as a result of injury or illness or to correct a congenital deformity or anomaly that results in a functional impairment.

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

Service
Service means a health care related procedure, surgery, consultation, advice, diagnosis, referrals, treatment, supply, medication, prescription drug, device or technology that is provided to a Participant by a Qualified Practitioner.

Service Area
Service Area means Baker, Benton, Clackamas, Clark (WA), Clatsop, Coos, Crook, Curry, Deschutes, Douglas, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath,

Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Payette (ID), Polk, Tillamook, Umatilla, Union, Walla Walla (WA), Wallowa, Wasco, Washington, Wheeler, and Yamhill counties within which Providence Choice In-Network Providers are available to deliver Covered Services under this Plan.

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

Substance Use Disorder
Substance use benefits are defined as benefits specifically designed to treat a Substance Use Disorder condition that falls under any of the diagnostic categories listed as a mental or behavioral disorder due to psychoactive substance use (or equivalent category) in the mental, behavioral, and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the ICD or that are listed in the most current version of the DSM.

Substituted Service
Substituted Service means payment for services or supplies that are not otherwise benefits of the Plan, but that Providence Health Plan determines to be Medically Necessary and cost effective subject to the requirements in section 4.6.

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

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

Telemedicine Visit
See section 5.1.2.3.

Urgent Care
See section 5.8.

Usual, Customary and Reasonable (UCR)
When a Service is provided by an In-Network Provider, UCR means the fees that Providence Health Plan has negotiated with In-Network Providers for that Service. UCR charges will never be less than our negotiated fees.

When a Service is provided by an Out-of-Network Provider, UCR charges will based on the lesser of:

1. The fee a professional provider usually charges for a given Service;
2. A fee which falls within the range of usual charges for a given Service billed by most professional providers in the same locality who have similar training and experience;
3. A fee which is based upon a percentage of the Medicare allowable amount;

4. A fee which is prevalent or which would not be considered excessive in a particular case because of unusual circumstances; or
5. The fee determined by comparing charges for similar Services to a national database adjusted to the geographical area where the Service was performed.

Oregon Hospitals Exception: Effective January 1, 2020, payment to Oregon hospitals for inpatient and outpatient hospital services provided to PEBB Members shall not exceed the following statutory reimbursement limits as set forth in ORS 243.256(2):

- For In-Network Hospitals: Payment shall be up to, but not exceeding, 200% of the amount paid by Medicare for the service or supply; and
- For Out-of-Network Hospitals: Payment shall be up to, but not exceeding, 185% of the amount paid by Medicare for the service or supply.

An Oregon hospital which is reimbursed in accordance with ORS 243.256(2) may not pursue, charge, or collect from the PEBB member/patient any amounts in addition to the reimbursement limits stated above, other than cost sharing amounts authorized by the terms of this Plan.

Oregon hospitals which are subject to this provision are as defined in ORS 243.256(5). This law does not apply to reimbursement of hospitals outside of Oregon.

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

Women's Health Care Provider

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

15. NON-DISCRIMINATION STATEMENT

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

Providence Health Plan and Providence Health Assurance:

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

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

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

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

LANGUAGE ACCESS INFORMATION

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-898-8174 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-898-8174 (TTY: 711).

Russian: ВНИМАНИЕ: Если Вы говорите по-русски, то Вам доступны услуги бесплатной языковой поддержки. Звоните 1-800-898-8174 (телетайп: 711).

Vietnamese: CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-800-898-8174 (TTY: 711).

Traditional Chinese: 注意：如果您說中文， 您可以免費獲得語言支援服務。請致電1-800-898-8174 (TTY: 711)。

Kushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-898-8174 (TTY: 711).

Farsi:
توجه: اگر به زبان فارسی صحبت میکنید، تسهیلات زبا ی ن به صورت رایگان به شما ارائه میشود. با 1-800-898-8174 (TTY: 711) تماس بگ ریید.

Ukrainian: УВАГА! Якщо Ви розмовляєте українською мовою, для Вас доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером 1-800-898-8174 (телетайп: 711).

Japanese: お知らせ：日本語での通話をご希望の場合、言語支援サービスを無料でご利用いただけます。1-800-898-8174（TTY: 711）まで、お電話ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-898-8174 (TTY: 711) 번으로 전화해 주십시오

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंले दनम्न भाषा सहायता सेवाहरू दन:शुल्क रूपमा उपलब्ध छन् । 1-800-898-8174 (TTY: 711) मा फोन गनु्होस् ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii gratuite de asistență lingvistică. Sunați 1-800-898-8174 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Rufnummer: 1-800-898-8174 (TTY: 711).

Hmong: LUS CEEB TOOM: Yog tias koj hais lus Hmoob, cov kev pab txhais lus, muaj kev pab dawb rau koj. Hu rau 1-800-898-8174 (TTY: 711).

Cambodian: កំណត់សម្គាល់៖ ប ើសិនជាអ្នកនិយាយភាសាខ្មែរ
អាចម្គនបសវាជំនួយខ្ជនកភាសាបោយមិនគិតថ្លៃពីបោកអ្នក។ សូមបៅទូរស័ពទបលម 1-800-898-8174 (TTY: 711)។

Laotian: ເຊີນຊາບ: ຖ້າວ່າທ່ານເວ ້າພາສາລາວ, ຈະມີການຊ່ວຍເຫ ຼືອ ດ້ ານພາສາ ໂດຍບ ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ 1-800-898-8174 (TTY: 711).

Administered by
Providence
Health Plan

Our Mission

As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Our Values

Compassion | Dignity | Justice | Excellence | Integrity

Questions? We're here to help.

Speak to one of our Member Advocates at **(855)284-1368**

Member Advocate Support:

Monday-Friday: 4:00 AM to 6:00 PM PT
Saturday: 7:00 AM to 11:00 AM PT
Sunday: Closed
Support Channel Type: Client Specific Phone Number, Chat

ProvidenceHealthPlan.com

Providence Health & Services, a not-for-profit health system, is an equal opportunity organization in the provision of health care services and employment opportunities.

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Effective January 01, 2026
Administered by Providence Health Plan
Powered by Collective Health