2023 Oregon Individual Contract

Connect

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

PROVIDENCE HEALTH PLAN QUICK REFERENCE GUIDE

Please see our Quick Reference Guide for customer service information.

Customer Service Quick Reference Guide:

General assistance with your Plan	503-574-7500 (local / Portland area) 800-878-4445 (toll-free) 711 (TTY) ProvidenceHealthPlan.com
Medical, Mental Health, and Substance Use Disorder Prior Authorization requests	800-638-0449 (toll-free) 503-574-6464 (fax)
Providence Nurse Advice Line	503-574-6520 (local / Portland area) 800-700-0481 (toll-free) 711 (TTY)
Provider Directory	ProvidenceHealthPlan.com/findaprovider
HealthCare.gov	800-318-2596 (toll-free) HealthCare.gov

Medical Home Selection / Updates:

Customer Service available Monday through Friday, 8 a.m. to 5 p.m. (Pacific Time)	503-574-7500 (local / Portland area) 800-878-4445 (toll-free)
Medical Home Selection Form	ProvidenceHealthPlan.com/medhomeform
Medical Home Selection Form mailing address	Providence Health Plan Attn: Customer Service P.O. Box 4327 Portland, OR 97208-4327
Medical Home Selection Form fax number	503-574-8208 (local / Portland area)

Monthly Premium Payment Options

Pay online	Providence.org/PremiumPay
Pay by phone	844-791-1467 (toll-free)
Pay by mail	Providence Health Plan P.O. Box 5728 Portland, OR 97228-5728

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1. INTRODUCTION

Thank you for choosing Providence Health Plan. We look forward to meeting your health care needs. The following is a brief outline of key provisions of your Providence Connect Individual & Family Plan Contract.

- Some capitalized terms have special meanings in this contract. Please see section 12, Definitions.
- In this document, Providence Health Plan is referred to as "we," "us" or "our." Members enrolled under this Contract are referred to as "you" or "your."
- In this document, your Individual & Family Plan is referred to as "Individual & Family Plan" or "Plan."
- If after examining this Contract you are not satisfied with it for any reason, you may cancel this policy within 10 days of receipt. Your decision to cancel this policy must be provided to us in writing within the 10-day period, and we will provide a full refund of your Premium and consider the policy void and never effective.
- Coverage under this Individual & Family Plan is provided through:
  - Our Providence Connect Network of Medical Homes and In-Network Providers.
- Covered Services must be obtained from In-Network Providers, with the following exceptions:
  - Emergency Services and Urgent Care Services, as specified in sections 4.5; and
  - Covered Services delivered by an Out-of-Network Provider when those Services have been approved in advance through the Prior Authorization procedures specified in section 3.6.
- 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.
- A printable directory of Medical Homes in our Service Area is available at: ProvidenceHealthPlan.com/findaprovider. Members without Internet access or who would like a hard copy of our Provider Directory, may contact Customer Service for assistance.
- **For Services outside of the Medical Home to be covered a referral is needed. You must obtain a referral from your Medical Home before you receive the Services.**
- **Certain Covered Services require an approved Prior Authorization, as stated in section 3.6.**
- Coverage under this Individual & Family Plan is available 24 hours a day, seven days a week and during periods of domestic or foreign travel.
- Enrolled Policyholders, enrolled Spouses, and Child-only Members must reside in our Service Area, as shown in section 13.
- The Contract for this Individual & Family Plan includes this document, the Benefit Summary, any endorsements or amendments that accompany those documents, and those policies maintained by Providence Health Plan which clarify any of these documents. In the event of any conflict between these documents, they are to be interpreted in the following order of priority: (1) endorsements and amendments, (2) Contract, (3) Benefit Summary, and (4) applicable Providence Health Plan policies.

2. WELCOME TO PROVIDENCE HEALTH PLAN

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

2.1 YOUR CONNECT PLAN

Your Connect Plan allows you to receive Covered Services from your Medical Home. Your Plan also provides coverage for Services to other In-Network Providers. You may access these providers through a Medical Home Referral. A woman can directly access a Women's Health Care Provider without a referral from her designated Medical Home.

IMPORTANT NOTE: A Medical Home referral can get you better coverage. It is required to receive In-Network benefits outside of your Medical Home. The provider must also be In-Network.

Your Medical Home will work with us to Prior Authorize treatment.

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

If you are unsure about a physician/provider's, Hospital's or other facility's participation with Providence Health Plan, visit our Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider, before you make an appointment. You also can call Customer Service to get information about a provider's participation with Providence Health Plan and your benefits. If you are searching for a Medical Home, be sure to confirm that the provider you have selected is a Medical Home for your Plan and is accepting new patients.

Whenever you visit a Provider:

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

Your Individual & Family Plan Contract contains important information about the health plan coverage we offer. It is important to read this Contract carefully as it explains your Providence Health Plan benefits and Member responsibilities. If you do not understand a term that is used, you may find it in Definitions, section 12. If you need additional help understanding anything in this document, please call Customer Service at 503-574-7500 or

800-878-4445. *See section 2.3 for additional information on how to reach Customer Service.*

This Individual & Family Plan Contract is not complete without your:

- **Providence Benefit Summary** and any endorsements or amendments to those documents. These documents are available at ProvidenceHealthPlan.com when you register for a myProvidence account as explained in section 2.4. Benefit Summaries detail your Copayments and Coinsurance for Covered Services and also provide important information about your Benefits.
- **Provider Directory** which lists In-Network Providers, available online at ProvidenceHealthPlan.com/findaprovider. If you do not have Internet access, please call Customer Service to obtain a hard copy of the directory.

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

2.3 CUSTOMER SERVICE

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

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

*If you're enrolled through HealthCare.gov, you will need to contact HealthCare.gov directly for assistance.

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

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

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

2.4 REGISTERING FOR A MYPROVIDENCE ACCOUNT

Members can create a myProvidence account online. A myProvidence account enables you to view your personal health plan information (including your Individual & Family Plan Contract and Benefit Summary), view claims history and benefit payment information, order a replacement Member ID Card, pay your monthly premium and access other health and wellness tools and services.

2.5 YOUR MEMBER ID CARD

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

- Your Member number; and
- Important phone numbers.

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

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

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

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

2.6 PROVIDENCE NURSE ADVICE LINE

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

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

Members often call the Providence nurse advice line when they have sick children, or when they have questions about how to treat flus, colds or backaches. After a brief recorded message, a registered nurse will come on line to assist you.

Please have your Member ID Card available when you call.

2.7 WELLNESS BENEFITS

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

- Providence Health Resource Line
    - Information on services, classes, self-help, smoking cessation and other services.
    - You can access by calling 503-574-6595 or 800-562-8964.
- Health education classes
    - Providence Health Plan Members may receive discounts on health education classes supporting smoking cessation, childbirth education and weight management.
    - You can access by calling the Providence Resource Line at 800-562-8964 or visiting providence.org/classes.

- Providence Health Coaching
    - Members can receive free coaching support for weight loss, diabetes prevention, nutrition, stress management, exercise, sleep and tobacco cessation.
    - You can access by calling 503-574-6000 (TTY: 711) or 888-819-8999 or visiting ProvidenceHealthPlan.com/healthcoach.
- Providence Care Management
    - Members can receive information and assistance with healthcare navigation and managing chronic conditions from a Registered Nurse Care Manager.
    - You can access by calling 800-662-1121 or emailing caremanagement@providence.org.
- Wellness information
    - You can find medical information, class information, information on extra values such as online tools and discounts and other information by visiting providence.org/healthplans.
- LifeBalance Program
    - Discounts on health, wellness, recreational and cultural activities.
    - You can access your LifeBalance program by calling 503-234-1375 or 888-754-LIFE or visiting LifeBalanceProgram.com.
- Travel Assistance Services,
    - Emergency logistical support to Members traveling internationally or people traveling 100 miles from home.
    - Contact by calling 609-986-1234 or 800-872-1414 or visit assistamerica.com.
- Identity Theft Protection
    - Identity theft protection program for Providence Health Plan Members
    - Please call 614-823-5227 or 877-409-9597 or visit assistamerica.com/Identity-Protection/Login to sign up for the program; you will need your Health Plan Member ID number, and tell them your code is 01-AA-PRV-01193.

2.8 PRIVACY OF MEMBER INFORMATION

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

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

For more information about uses and disclosures of Member information, including uses and disclosures required by law, please refer to our Notice of Privacy Practices. A copy is available at https://healthplans.providence.org/members/rights-notices/ or by calling Customer Service.

Appointment of Authorized Representative

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

3. 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 is your Primary Care Provider. They can provide most of your care and provide referrals to specialists. They can also arrange for Hospital care or diagnostic testing.

This section describes how to use this Plan and how benefits are applied. The level of benefits for Covered Services is shown in the Benefit Summary and described in section 4 of this document.

3.1 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 ProvidenceHealthPlan.com/findaprovider. If you do not have access to our website, please call Customer Service to request In-Network Provider information.

3.1.1 Choosing or Changing a Medical Home

Upon joining this Plan, you and each of your enrolled Family Members must choose a Medical Home as soon as possible. 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.

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

- **Online:** Visit myProvidence to log into your account and select a Medical Home for you or your family*
- **Mail:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com/medhomeform. Mail your completed form to:
  Providence Health Plan
  Attn: Customer Service
  P.O. Box 4327
  Portland, OR 97208-4327
- **Phone:** Call Customer Service at 503-574-7500 or 800-878-4445, Monday through Friday, 8 a.m. to 5 p.m.
- **Fax:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com/medhomeform. Fax your completed form to 503-574-8208.

*Adults age 18 and over must log into myProvidence separately to select their own medical homes.

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 such change in your Medical Home selection to Providence Health Plan by using any of the notification methods listed above.

If you do not communicate your selection or change in selection to Providence Health Plan before seeking services, your services may not be covered.

Advantages of Using a Medical Home

- Your Medical Home will work with Providence Health Plan. They will arrange any Referral requirements that may be needed for certain Covered Services. More information is in section 3.6.
- Your Medical Home will coordinate care, when necessary, with a wide variety of high quality In-Network Providers to help you with your health care needs.

3.1.2 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 ihs.gov, or contact the regional IHS office at:

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

3.2 THE ROLE OF A 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, coordinate care with other providers in a convenient and cost-effective manner.

3.2.1 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; a certified nurse midwife; or a physician assistant, when providing services under the supervision of a physician; who agrees to be responsible for the Member's continuing medical care by serving as case manager. Members may choose and self-refer to a Qualified Practitioner specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Medical Home Primary Care Provider. Child Members may choose a physician specializing in pediatrics as their Medical Home Primary Care Provider.

Medical Home Primary Care Providers provide preventive care and health screening, medical management of many chronic conditions, allergy shots, treatment of some breaks and sprains, and care for many major illnesses and nearly all minor illnesses and conditions. Many Medical Home Primary Care Providers offer maternity care and minor outpatient surgery as well.

IMPORTANT NOTE: Medical Home Primary Care Providers have a special agreement with us to serve as a case manager for your care. This means not all of our Medical Home Providers with the specialties listed above are Medical Home Primary Care Providers. Please see our

online Provider Directory for a listing of designated Medical Home Primary Care Providers or call your Customer Service team to obtain a paper copy.

3.2.2 Established Patients with Primary Care Providers

If you and your family already see a provider, you may want to check the provider directory to see if your provider is 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.

3.2.3 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.

3.2.4 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 Medical Home 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. They may also discuss with you the need for other specialist services. If necessary, they will refer you to an In-Network specialist for treatment. Your Medical Home will then coordinate your care. This may include sharing important information with your specialist. You must get a referral to receive covered services from a specialist.

Whenever you visit a specialist:

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

Alternative Care Providers

Your Plan includes coverage for office visits to naturopaths, chiropractors, and acupuncturists, as listed in your Benefit Summary. See section 12 for the definition of Alternative Care Provider. For coverage of chiropractic manipulation and acupuncture, see sections 4.12.13, 4.12.14 and your Benefit Summary.

3.3 SERVICES PROVIDED WITHOUT MEDICAL HOME REFERRAL OR BY OUT-OF-NETWORK PROVIDERS

Providence Health Plan may approve and provide reimbursement for Out-of-Network Qualified Providers. You must receive written approval to see Out-of-Network Providers, before you receive services. Providence will only give approval if we determine in advance that the Out-of-Network Provider possesses unique skills which are required to suitably care for you and are not available from In-Network Providers. If approved, benefits and cost shares will be as shown on the Benefit Summary.

If Services from Out-of-Network providers are not Prior Authorized they will not be covered. With the exception being Emergency and Urgent Care. This also applies to Services received from facilities.

IMPORTANT NOTE: Your Plan only pays for Covered Services received from approved, Prior Authorized Out-of-Network Providers at Usual, Customary, and Reasonable rates (UCR) (see Section 12, Definitions). If an Out-of-Network Provider charges more than the UCR rates allowed under your Plan, that provider may bill you directly for the additional amount that is not covered by your Plan. That amount is in addition to any Deductible, Copayment, or Coinsurance for which you may be responsible, and does not accrue to your Out-of-Pocket Maximum.

If you choose to receive Covered Services from an approved, Prior Authorized Out-of-Network Provider, those Services are still subject to the terms of this Contract. 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 Contract are not covered.

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.

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

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

If we have approved an Out-of-Network Provider and if the Services provided are Medically Necessary Covered Services, we will provide payment to Out-of-Network Providers according to Usual, Customary and Reasonable (UCR) charges. UCR charges do not include sales taxes, handling fees and similar surcharges; such taxes, fees and surcharges are not

covered expenses. Charges which exceed UCR are the Member's responsibility and are not applied to the Out-of-Pocket Maximum. See section 12 for the definition of UCR.

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

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

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

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

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

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

3.3.1 Understanding Protections Against Surprise Medical Bills

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

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

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

"Out-of-Network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-Network Providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is

called “balance billing.” This amount is likely more than In-Network costs for the same service and might not count toward your annual Out-of-Pocket Maximum.

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

You are protected from balance billing for:

Emergency Services

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

Certain services at an In-Network Hospital, Independent Freestanding Emergency Department or Ambulatory Surgical Center

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

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

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

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

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

Your health plan generally must:

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

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

For assistance outside of Providence Health Plan:

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

3.4 MOVING INTO OR OUT OF THE SERVICE AREA

If you or a Family Member permanently moves into or out of the Service Area, you must immediately notify us as such a move may affect your benefits or coverage under this Plan. We will determine how this move affects your coverage and will inform you of any changes. If you have Dependent(s) who move in or out of our Service Area, a Change of Status form for those Dependent(s) must be completed and returned to us as soon as possible. This form can be obtained from Providence Health Plan. See sections 8.1.1, 8.2.1, and 8.5 for more information. If you enrolled through HealthCare.gov, please contact HealthCare.gov directly to inform them of your changes in Service Area.

3.5 NOTICE OF PROVIDER TERMINATION

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

3.6 PRIOR AUTHORIZATION

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

Services received from Medical Homes or with a Medical Home Referral:
Some Services from a Medical Home need Prior Authorization. The Provider must obtain this. This is true for Services completed from an In-Network Provider through a medical Home Referral as well.

Services received without Medical Home Referral or from Out-of-Network Providers:
You must submit Prior Authorization if you do not have a referral. To receive Prior Authorization contact Providence Health Plan. The Out-of-Network Provider may also contact Providence Health Plan. Further details can be found in section 3.3.

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

Providence Health Plan will provide a Prior Authorization form upon oral or written request. If you need information on how to obtain Prior Authorization, please call Customer Service at the number listed on your Member ID card.

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

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

- The Member's name and date of birth.
- The Member's Providence Health Plan Member number and plan number (these are listed on your Member ID card).
- The Provider's name, address and telephone number.
- The name of the Hospital or treatment facility.
- The scheduled date of admission or date Services are to begin.
- The Service(s) to be performed.

3.7 TRAVEL EXPENSE REIMBURSEMENT

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

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

3.8 MEDICAL COST MANAGEMENT

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

We may use or share your information with others to help manage your health care. For example, we might talk to your Qualified Practitioner to suggest a disease management or wellness program that could improve your health.

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

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

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

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

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

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

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

3.8.1 Coverage of New Technology and New Application of Existing Technology

New technologies and new applications of existing technologies are evaluated and approved for coverage when they provide a demonstrable benefit for a particular illness or disease, are scientifically proven to be safe and most effective, and there is no equally effective or less costly alternative.

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

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

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

- Technology must improve health outcomes. The beneficial effects must outweigh any harmful effects on health outcomes. It must improve the length of life, ability to function or quality of life.

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

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

<u>Expedited Review</u>
Requests for coverage of new technology may occur before formal policy has been developed. In these cases, an expedited review is implemented and a decision made on a case-by-case basis. This is separate and distinct from the problem resolution procedure set forth in section 7.

3.9 MEDICALLY NECESSARY SERVICES

We believe you are entitled to comprehensive medical care within the standards of good medical practice. Our medical directors and special committees of In-Network Providers determine which Services are Medically Necessary, as defined in section 12. Services that do not meet Medically Necessary criteria will not be covered.

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

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

3.10 APPROVED CLINICAL TRIALS

Benefits are provided for Covered Services directly related to a Member's participation in an Approved Clinical Trial offered through an In-Network Provider.

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

You may choose to participate in an Approved Clinical Trial offered through an Out-of-Network Provider, however, coverage will only be provided for Medically Necessary services received In-Network in treatment of an illness or injury.

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;
- The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- The cost for any services received Out-of-Network.

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

3.11 HOW BENEFITS ARE APPLIED

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

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

3.12 DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS

Your Plan has Deductibles and Out-of-Pocket Maximums, as stated in your Benefit Summary.

Deductible amounts apply to Out-of-Pocket Maximums.

3.12.1 Understanding Deductibles

Your Deductible is the dollar amount shown in the Benefit Summary that you are responsible to pay every Calendar Year for Covered Services before benefits are provided by us. Deductible amounts are payable to your Qualified Practitioner after we have processed your claim.

Certain Covered Services, such as most In-Network preventive care, are covered without a Deductible. Please see your Benefit Summary for information about these Services.

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

Family Deductible: Family Deductible is the amount shown in the Benefit Summary that applies when two or more Family Members are enrolled in this Contract, and is the maximum Deductible that enrolled Family Members must pay. All amounts paid by Family

Members toward their Individual Deductibles apply toward the Family Deductible. When the Family Deductible is met, no further Individual Deductibles will need to be met by any enrolled Family Members.

Note: No Member will ever pay more than an Individual Deductible before the Plan begins paying for Covered Services received from 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 Contract;
- Services in excess of any maximum benefit limit;
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges; and
- Copayments or Coinsurance specified as not applicable toward the Deductible in any Benefit Summary issued with this Contract.

3.12.2 Understanding Out-of-Pocket Maximums

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

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

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

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

- Services not covered by this Contract;
- Services not covered because Prior Authorization was not obtained, as required in section 3.6;
- Services in excess of any maximum benefit limit;
- Deductibles, Copayments or Coinsurance amounts for Adult Vision;
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges; and
- Deductibles, Copayments or Coinsurance for a Covered Service if indicated in any Benefit Summary as not applicable to the Out-of-Pocket Maximum.

IMPORTANT NOTE: Some Covered Services are NOT eligible for 100% benefit coverage. If a Covered Service is indicated as not applying toward the Out-of-Pocket Maximum, the

Copayment or Coinsurance for this Service that is shown in the Benefit Summary remains in effect throughout the Calendar Year.

4. COVERED SERVICES

This section describes Services that, when Medically Necessary and not otherwise excluded or limited, are covered under this Contract. See your Benefit Summary for the Deductibles, Copayments, Coinsurance and Out-of-Pocket Maximums that apply to Covered Services.

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

This Plan provides coverage of Essential Health Benefits as required by the Patient Protection and Affordable Care Act and related legislation. See section 12 for the definition of Essential Health Benefits.

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

4.1 PREVENTIVE SERVICES

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

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

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

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

4.1.1 Physical Examinations and Well-Baby Care

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

section 4.15 for coverage of pediatric vision. In order for a child to be eligible for benefits for routine newborn baby care, the child must be properly enrolled as outlined in section 8. Ancillary Services, such as immunizations, are covered at the specified benefit level when billed by the provider.

Recommended Guidelines:

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

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

4.1.2 Immunizations and Vaccinations

Benefits for immunizations and vaccinations are provided in accordance with accepted medical practice. Visits to your Qualified Practitioner's office or Participating Pharmacy for immunizations or injections are subject to the Copayment or Coinsurance shown in the Benefit Summary. Some immunizations may require Prior Authorization.

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

4.1.3 Prostate Cancer Screening Exams

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

4.1.4 Colorectal Cancer Screening Exams

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

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

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

For Members age 45 and older:

- All Services for colorectal cancer screenings and exams are covered in full, including prescription drug bowel prep kits, as listed in our formulary.

For Members under age 45:

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

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

4.1.5 Preventive Services for Members with Diabetes

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

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

4.1.6 Diabetes Self-Management Education Program

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

4.1.7 Nutritional Counseling

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

4.1.8 Tobacco Use Cessation Services

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

4.2 WOMEN’S PREVENTIVE HEALTH CARE SERVICES

Women may choose to receive Women’s Preventive Health Care Services from a Primary Care Provider or a Women’s Health Care Provider without a referral. Women’s Health Care Providers include physicians specializing in obstetrics, some Primary Care Providers and naturopaths (if they are licensed to provide the Services), physician assistants and nurse

practitioners specializing in women's health care, certified nurse midwives and licensed direct entry midwives.

4.2.1 Gynecological Examinations

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

4.2.2 Mammograms

Mammograms are covered for women 40 years of age and over once every Calendar Year. If the Member is designated high risk, mammograms are provided at the recommendation of your Qualified Practitioner or Women's Health Care Provider.

4.2.3 Breastfeeding Counseling and Support

Coverage for lactation counseling is provided when Medically Necessary as determined by the Qualified Practitioner. Benefits include coverage in full for breast pump equipment and supplies when rented or purchased through our Network Medical Equipment Providers.

4.2.4 Family Planning Services

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

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

- Intrauterine device (IUD) insertion and removal;
- Medical exams and consultation for family planning;
- Depo-Provera to prevent pregnancy;
- Diaphragm devices;
- Removal of implantable contraceptives; and
- Oral contraceptives (birth control pills) listed in our Formulary.

Services are covered in full and must be received from In-Network Providers and Facilities or purchased from Participating Pharmacies.

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

4.3 PROVIDER SERVICES

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

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

For example – You see your Primary Care Provider for an office visit and during your visit your provider swabs your throat for a throat culture. You would pay your office visit

Copayment or Coinsurance and would also need to pay the Laboratory Services Copayment or Coinsurance for the throat culture. See your Benefit Summary for details.

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

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

4.3.2 Telehealth Services

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

Selected ZIP codes in the following Oregon counties:

Yamhill – 97123, 97132

4.3.2.1 On-Demand Virtual Visits

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

4.3.2.2 Office Visits Virtually

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

4.3.2.3 Telemedical Services

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

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

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

guardian of a Member or another health professional on a Member's behalf, who is at an originating site.

4.3.3 E-mail Visits

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

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

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

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

- Renewing prescriptions;
- Scheduling tests;
- Scheduling appointments;
- Reporting normal test results;
- Recommending a referral to another physician;
- A consultative message exchange from a patient who is seen in-person immediately afterward as a result of the consultative message;
- A brief follow-up of an office visit, medical procedure or other treatment to confirm stable condition;
- A brief discussion to confirm stability of a chronic problem and continuity of present management of the problem;
- All communications in connection with Mental Health or Substance Use Disorder Services, as provided in section 4.10.

4.3.4 Telephone Visits

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

4.3.5 Allergy Shots, Allergy Serums, Injectable and Infused Medications

Allergy shots, allergy serums, injectable and infused medications, and total parenteral nutrition (TPN) received in your Provider's office are covered, as shown in your Benefit Summary. Therapy and testing for treatment of allergies including, but not limited to, Services related to clinical ecology, environmental allergy and allergic immune system

dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment are covered only when such therapy or testing is approved by The American Academy of Allergy and Immunology, or The Department of Health and Human Services or any of its offices or agencies. Some injectable medications may require Prior Authorization, as listed in the Medical benefit drug prior authorization list available on our website at https://healthplans.providence.org/members/pharmacy-resources/Pages/default.aspx or by calling Customer Service. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. See section 4.7.1 for coverage of infusion at Outpatient Facilities.

4.3.6 Administration of Anesthesia and Surgical Procedures

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

4.3.7 Immediate Care

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

Whenever you need immediate care, call your Primary Care Provider first. Your Primary Care Provider or the provider-on-call is always available, day or night. He or she may either suggest that you be seen at your Primary Care Provider's office or direct you to an immediate care center, Urgent Care or emergency care facility. See section 4.5 for coverage of Emergency Care and Urgent Care Services.

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

4.3.8 Retail Health Clinic

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

4.4 DIAGNOSTIC SERVICES

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

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

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

4.4.2 Sleep Study Services

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

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

4.5 EMERGENCY CARE AND URGENT CARE SERVICES

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

4.5.1 Emergency Care

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

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

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

<u>Definitions:</u>

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

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

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

- A medical screening exam or behavioral health assessment that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition;
- Such further medical examination and treatment as are required under the Emergency Medical Treatment and Active Labor Act (42 U.S.C. 1395dd) to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at the Hospital or Independent Freestanding Emergency Department; and
- Covered Services provided by staff or facilities of a Hospital or Independent Freestanding Emergency Department after the Member is stabilized and as part of outpatient observation or an inpatient or outpatient stay, including poststabilization 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 Contract covers Emergency Services in the emergency room of any Hospital or Independent Freestanding Emergency Department.

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

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

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

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

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

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

If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will not be covered.

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

4.5.2 Emergency Medical Transportation

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

4.5.3 Emergency Eye Care Services

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

4.5.4 Emergency Detoxification Services

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

4.5.5 Urgent Care

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

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

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

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

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

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

If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will not be covered.

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

4.6 INPATIENT HOSPITAL AND SKILLED NURSING FACILITY SERVICES

Coverage is provided, as shown in your Benefit Summary for Hospital and Skilled Nursing Facility Services.

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

- Room and board and supervisory or custodial Services.
- Personal hygiene and other forms of self-care.
- Non-skilled care for senile deterioration, mental deficiency, or developmental disability.

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.
- Take-home medications, supplies and equipment.
- Personal items such as telephone, radio, television and guest meals.

4.6.1 Inpatient Hospital Services

Benefits are provided, as shown in the Benefit Summary.

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.

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

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

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

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

4.6.2 Skilled Nursing Facility

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

4.6.3 Inpatient Rehabilitative Care

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

4.6.4 Inpatient Habilitative Care

Coverage is provided, as shown in the Benefit Summary, for Medically Necessary inpatient habilitative care. If a Member is hospitalized when habilitative Services begin, habilitative benefits will begin on the day treatment becomes primarily habilitative. All Services must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. (See section 4.7.3 for coverage of Outpatient Habilitative Services.)

4.6.5 Observation Care

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

4.7 OUTPATIENT SERVICES

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

Benefits are provided, as shown in the Benefit Summary and include Services at a hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, osteopathic manipulation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, radiation oncology, therapeutic procedures, and approved multidisciplinary pain management programs as ordered by your Qualified Practitioner. Some injectable medication may be required to be supplied by a contracted Specialty Pharmacy or a preferred site of care, and some infused medications may need to be administered at a designated location only if preferred location is less than 15 miles from a member's home. Member may utilize home infusion or their local site of care if no preferred site of care is located within 15 miles from a member's home. We may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, we will not Prior Authorize the Services. For additional information about Prior Authorization, see section 3.6.

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

4.7.2 Outpatient Rehabilitative Services

Benefits are included for outpatient physical, occupational and speech therapy Covered Services provided by a physician or licensed/registered therapist, as stated in the Benefit Summary, to restore or improve lost function following illness or injury. Additional visits will be covered when criteria are met for the following conditions:

- Neurological disorders (e.g., stroke, spinal cord injury, head injury, pediatric neurodevelopmental disorders); and
- Pervasive developmental disorders.

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). All Services are subject to review for Medical Necessity.

Providers make notifications for outpatient rehabilitation services through an authorizing agent. A notification is submitted to the authorizing agent for initial and/or ongoing outpatient rehabilitation services informing Providence Health Plan that you are receiving physical therapy and/or occupational therapy services. The authorizing agent determines if the requests are approved or require medical necessity review. For more information, visit our website at ProvidenceHealthPlan.com/OutpatientRehab

Covered Services under this benefit do **NOT** include:

- Chiropractic adjustments and manipulations of any spinal or bodily area;

- Exercise programs;
- Rolfing, polarity therapy and similar therapies; and
- Rehabilitation services provided under an authorized home health care plan, as stated in section 4.11.

See section 4.6.3 for coverage of Inpatient Rehabilitative Services.

4.7.3 Outpatient Habilitative Services

Coverage is provided, as shown in the Benefit Summary, for Medically Necessary Outpatient Habilitative Services for maintenance, learning or improving skills and function for daily living. Additional visits will be covered when criteria are met for the following conditions:

- Neurological disorders (e.g., stroke, spinal cord injury, head injury, pediatric neurodevelopmental disorders); and
- Pervasive developmental disorders.

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. See section 4.6.4 for coverage of Inpatient Habilitative Services.

4.8 MATERNITY SERVICES

Your benefits include coverage for comprehensive maternity care.

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

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

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

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

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

PLEASE NOTE: Newborn nursery care, newborn nurse home visits, and any other Services provided to your newborn are covered only when the newborn child is properly enrolled under this Plan within time frames outlined in Newborn, Newly Adopted Children, and Newly Fostered Children Eligibility and Enrollment, section 8.3.

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

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

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

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

Maternity support Services: Members may attend a class to prepare for childbirth. The classes are held at In-Network Hospitals. Call the Providence Resource Line at 503-574-6595 or visit providence.org/classes for information on classes, specific dates, locations, registration and prices. Classes vary by geographic area. In addition, Members with high-risk pregnancies may receive support services through care or case management. A care manager may be a social worker or a registered nurse.

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

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

Benefits for medical supplies, medical appliances, prosthetic and orthotic devices and Durable Medical Equipment (DME) are provided, as shown in the Benefit Summary when

required for the standard treatment of illness or injury. We may authorize the purchase of an item if we determine the cost of purchasing an item would be less than the overall rental of the item. Services must be prescribed by a Qualified Practitioner.

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

4.9.1 Medical Supplies (including Diabetes Supplies)

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

1. Medically Necessary supplies as ordered by your Qualified Practitioner, including, but not limited to, ostomy supplies, prescribed needles, syringes and chem strips. Non-sterile examination gloves used by you or your caregiver are NOT a covered medical supply.
2. Diabetes supplies, such as needles, syringes, continuous glucose monitors and blood glucose monitors, lancets and test strips, may be purchased through Providence Health Plan participating medical supply providers or under this benefit at Participating Pharmacies. Formulary, Prior Authorization, and quantity limits may apply – please see your Formulary for details. See section 4.9.4 for coverage of diabetic equipment such as insulin pump devices.
3. Medically Necessary medical foods for supplementation or dietary replacement including non-prescription elemental enteral formula for home use, when determined to be Medically Necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition. Medical foods are also covered for the treatment of Inborn Errors of Metabolism, as described in section 4.12.2. Medical foods do not include total parenteral nutrition (TPN), which is covered under section 4.3.5.

4.9.2 Medical Appliances

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

1. Casts, braces and supportive devices when used in the treatment of medical or surgical conditions in acute or convalescent stages or as immediate post-surgical care.
2. Initial and replacement contact lenses, intraocular lenses, prescription lenses or standard frame glasses, when required as a result of injury, illness or surgery, such as, but not limited to, cataract, corneal transplant surgery or for the treatment of keratoconus.
3. Rental of an oxygen unit used in the home for Members with significant hypoxemia who are unresponsive to other forms of treatment. The benefit is limited to three months from the initial date of Service unless there is clinical evidence of the need to continue.
4. Removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are subject to the benefit maximum stated in the Benefit Summary.

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

4.9.3 Prosthetic and Orthotic Devices

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

4.9.4 Durable Medical Equipment (DME)

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

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

4.10 MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

This Contract complies with Oregon and Federal Mental Health Parity.

4.10.1 Mental Health Services

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

Covered Services include diagnostic evaluation, individual and group therapy, inpatient hospitalization, as stated in section 4.6.1, residential, day, intensive outpatient or partial hospitalization Services. All inpatient, residential, day, intensive outpatient or partial hospitalization treatment Services must be Prior Authorized.

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 outpatient treatment, or as soon as reasonably possible.

4.10.2 Applied Behavior Analysis

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

- Services must be Medically Necessary;

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

Exclusions to ABA Services:

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

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.

4.10.3 Substance Use Disorder Services

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

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

Prior Authorization is required for all inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services.

Treatments involving the use of methadone are a Covered Service only when such treatment is part of a medically-supervised treatment program that has been Prior Authorized.

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

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

4.11 HOME HEALTH CARE AND HOSPICE CARE

4.11.1 Home Health Care

Benefits for home health care Covered Services are shown in the Benefit Summary and, as stated in this section. 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 Contract.

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

Home health care will not be reimbursed unless your Qualified Practitioner certifies that the home health care Services will be provided or coordinated by a state-licensed or Medicare-certified Home Health Provider or certified rehabilitation agency.

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

If the above criteria are not met, NO benefits will be provided under this Contract for home health care.

Rehabilitation services provided under an authorized home health care plan will be covered as home health care Services.

Home health care benefits do NOT include:

1. Charges for mileage or travel time to and from your home;
2. Wage or shift differentials for Home Health Providers;
3. Charges for supervision of Home Health Providers; or
4. Services that consist principally of Custodial Care including, but not limited to, care for senile deterioration, mental deficiency, mental illness, developmental disability or care of a chronic or congenital condition on a long-term basis.

4.11.2 Hospice Care

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

In addition, the following criteria must be met:

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

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

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

Respite care is limited to Members receiving Hospice Care and is covered, as shown in your Benefit Summary.

4.12 OTHER COVERED SERVICES

4.12.1 Genetic Testing and Counseling Services

Genetic testing and counseling are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature. Select genetic testing requires Prior Authorization, for more information see section 3.6.

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

4.12.2 Inborn Errors of Metabolism

We will provide benefits for Covered Services, as shown in the Benefit Summary based upon the type of Services received for diagnosing, monitoring and controlling inborn errors of metabolism, including, but not limited to: phenylketonuria (PKU); homocystinuria; citrullinemia; maple syrup disease; and pyruvate dehydrogenase deficiency; that involve amino acid, carbohydrate and fat metabolism for which medically standard methods exist, including quantification of metabolites in blood, urine, spinal fluid or enzyme or DNA confirmation in tissues. Covered Services include clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. For coverage of medical foods, see section 4.9.1.

4.12.3 Podiatry/Foot Services

Benefits include Covered Services of a podiatrist or other Qualified Practitioner and are provided, as shown in the Physician/Provider Services section of the Benefit Summary. Covered Services include, but are not limited to, the fitting and follow up exam for removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are covered, as stated in section 4.9.2

(Medical Appliances). Covered Services do not include routine foot care and the removal of corns or calluses, unless you have diabetes.

4.12.4 Reconstructive Surgery

Reconstructive Surgery is covered for conditions resulting from congenital defects, developmental abnormalities, trauma, infection, tumors or disease. Reconstructive surgery may be performed to correct a functional impairment in which the special, normal or proper action of any body part or organ is damaged; when necessary because of accidental injury or to correct scars or defects from accidental injury; or when necessary to correct scars or defects to the head or neck resulting from covered surgery. Benefits are covered as those Services listed in the Benefit Summary based upon the type of Services received. For Restoration of Head or Facial Structures; Limited Dental Services, see section 4.12.6.

4.12.5 Reconstructive Breast Surgery

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

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

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

If you have additional questions about your WHCRA benefits, please contact Customer Service.

4.12.6 Restoration of Head/Facial Structures; Limited Dental Services

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

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

Exclusions that apply to Covered Services include:

- Cosmetic Services;
- Services rendered to improve a condition that falls within the normal range of such conditions;
- Routine Orthodontia;

- Services to treat tooth decay, periodontal conditions and deficiencies in dental hygiene;
- Removal of impacted teeth;
- The making or repairing of dentures;
- Orthognathic surgery to treat developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth; and
- Services to treat temporomandibular joint syndrome, including orthognathic surgery.

Outpatient Hospitalization and Anesthesia for Limited Dental Services

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

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

Dental Services are excluded, unless covered under the Pediatric Dental Benefit.

4.12.7 Self-Administered Chemotherapy

Self-administered chemotherapy agents, including oral, topical and injectable medications that are used to stop or slow the growth of cancerous cells, are covered when received from a Participating retail or specialty Pharmacy.

Self-administered chemotherapy is covered under the Prescription Drug Benefit unless the Outpatient Chemotherapy coverage results in a lower out-of-pocket expense to the Member. See sections 4.7.1, 4.14 and your Benefit Summary.

4.12.8 Biofeedback

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

4.12.9 Elective Sterilization

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

Services are covered in full and must be received from In-Network Providers and Facilities.

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

4.12.10 Gender Dysphoria

Benefits are provided for gender affirming Services for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and

select surgical procedures as outlined in our medical policy. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable Inpatient or Outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.6 for more information on services requiring Prior Authorization.

4.12.11 Hearing Loss Services

Definitions:

Cochlear Implant

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

Hearing Aid

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

Covered Services:

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

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

Cochlear Implants:

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

Hearing Aids & related accessories:

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

Diagnostic & Treatment Services:

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

Hearing Assistance Technology:

- Bone conduction sound processors, if necessary for appropriate amplification of hearing loss. This benefit is available once every 3 Calendar Years for all Members.
- Hearing assistive technology systems, if necessary, for appropriate amplification of hearing loss. This benefit is available once every 3 Calendar Years for all Members.

Limits to Hearing Loss Services

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

4.12.12 Wigs

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

4.12.13 Chiropractic Manipulation

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

4.12.14 Acupuncture

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

4.12.15 Fertility Preservation Services

The Plan covers Fertility Preservation where treatment related to cancer conditions may cause irreversible infertility as recommended by evidence-based guidelines such as the National Comprehensive Cancer Network (NCCN).
Covered Services include the following:

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

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

4.12.16 Orthoptics and Vision Training

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

4.13 HUMAN ORGAN/TISSUE TRANSPLANTS

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

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

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

4.13.1 Covered Services

Covered Services for transplants are limited to Services that:

1. Are determined by us to be Medically Necessary and medically appropriate according to national standards of care;
2. Are provided at a facility approved by us or under contract with us;
3. Involve one or more of the following organs or tissues:
    - Heart
    - Lung
    - Liver
    - Kidney
    - Pancreas
    - Small bowel
    - Autologous hematopoietic stem cell/bone marrow
    - Allogeneic hematopoietic stem cell/bone marrow; and
4. Are directly related to the transplant procedure, including Services that occur before, during and after the transplant procedure.

Covered Services for transplant recipients include medical Services, hospital Services, medical supplies, medications and prescription drugs while hospitalized, diagnostic modalities, prosthesis, high dosage chemotherapy for stem cell/bone marrow transplants, and travel expenses. Travel expenses are subject to a $5,000 per transplant benefit maximum for transportation, food and lodging. Food and lodging is subject to a $300 per diem. Per Diem expenses apply to the $5,000 travel expenses per transplant benefit maximum. (Note: Travel Services are not covered for donors.)

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

1. Initial evaluation of the donor and related program administration costs;
2. Preserving the organ or tissue;
3. Transporting the organ or tissue to the transplant site;
4. Acquisition charges for cadaver or live donor;
5. Services required to remove the organ or tissue from the donor; and
6. Treatment of medical complications directly resulting from the surgery performed to obtain the organ or tissue for a period of time not to exceed 30 consecutive days following that surgery.

4.13.2 Benefits for Transplant Facility Services Provided to the Organ Recipient

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

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

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

4.13.3 Benefits for Outpatient Medications

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

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

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

4.13.5 Transplant Prior Authorization

(See also section 3.6.)

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

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

4.13.6 Transplant Exclusions

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

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

4.14 PRESCRIPTION DRUG BENEFIT

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

Self-Administered Prescription Drug Definition

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

The following are considered "Self-Administered Prescription Drugs:"

1. Any medicinal substance which bears the legend, "RX ONLY" or "Caution: federal law prohibits dispensing without a prescription;"
2. Insulin;
3. Any medicinal substance of which at least one ingredient is a federal legend drug in a therapeutic amount; and
4. Any medicinal substance which has been approved by the Oregon Health Evidence Review as effective for the treatment of a particular indication.

Prescription Drugs, including oral, topical and injectable medications delivered, injected or administered to you by a physician, other provider, or trained person in a Provider's office or other facility are not covered under your Prescription Drug Benefit. Prescription drugs administered in a Provider's office or other facility are subject to the applicable benefit. For example, Prescription Drugs delivered in a Provider's Office are subject to your Allergy Shots, Allergy Serums, Injectable and Infused Medications benefit. See section 4.3.5. Select self-administered injectable medications may allow for a 60-day transition period 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.

4.14.1 Using Your Prescription Drug Benefit

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

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

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

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

- Please present your Member ID Card to the Participating Pharmacy at the time you request Services. If you have misplaced or do not have your Member ID Card with you, please ask your pharmacist to call us.
- All Covered Services are subject to the Deductible, Copayments and/or Coinsurance listed in your Benefit Summary. Benefit maximums may also apply as defined in the contract.
- If a generic equivalent exists or becomes available, or if the cost of a brand-name drug changes, the tier placement of the brand-name drug may change, may require Prior Authorization, or the brand-name drug may no longer be covered. Additionally, if you choose a brand-name drug when a generic is available, you will be required to pay for the difference in cost between the brand-name drug and the generic drug, and the difference in cost will not apply to your Calendar Year Deductibles and Out-of-Pocket Maximums.
- The amount paid by a manufacturer discount and/or copay assistance programs will apply towards your Calendar Year Deductibles and Out-of-Pocket Maximums.
- Participating Pharmacies may not charge you more than your Copayment or Coinsurance, except when Deductible and/or coverage limitations apply. Please contact Customer Service if you are asked to pay more or if you, or the pharmacy, have questions about your Prescription Drug Benefit or need assistance processing your prescription.
- Copayments or Coinsurance are due at the time of purchase. If the cost of your Prescription Drug is less than your Copayment, you will only be charged the cost of the Prescription Drug.
- You may be assessed multiple Copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- You may purchase up to a 90-day supply of each maintenance drug at one time using a Participating mail service or preferred retail Pharmacy. Not all drugs are covered for more than a 30-day supply, including compounded medications, drugs obtained from specialty pharmacies, and limited distribution pharmaceuticals. To obtain prescriptions by mail, your physician or provider can call in or electronically send the prescription, or you can mail your prescription along with your Providence Health Plan Member ID number to one of our Participating mail-order Pharmacies. To find our Participating mail-order Pharmacies, please visit our website at ProvidenceHealthPlan.com. (Not all prescription drugs are available through our mail-order pharmacies).
- Providence Health Plan will provide Members prescription synchronization services for maintenance medications. Upon Member or provider request, the Plan will coordinate with Members, providers, and the dispensing pharmacy to synchronize

maintenance medication refills so Members can pick up maintenance medications on the same date. Members will be responsible for applicable Copayments, Coinsurances and Deductibles.

- Diabetes supplies and inhalation extender devices may be obtained at your Participating Pharmacy. However, these items are considered medical supplies and devices and are subject to your Medical Supplies benefits, limitations and Copayments and/or Coinsurances. See section 4.9.1 and your Benefit Summary. Diabetes supplies do not include insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.9.4.
- Self-administered chemotherapy drugs are covered under section 4.12.7 unless the benefits under this Prescription Drug Benefit allow for lower out of pocket costs to you.
- Self-administered injectable medications are not covered when supplied in a Provider's office, clinic or facility. Injectable or infused medications received in your Provider's office are covered by your medical benefit found in section 4.3.5. Select self-administered injectable medications may allow for a 60-day transition period 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.
- Infusions, including infused medications, received at Outpatient Facilities are covered under section 4.7.1.
- Some prescription drugs require Prior Authorization or an exception to the formulary in order to be covered; these may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in our Prescription Drug Formulary available on our website at ProvidenceHealthPlan.com or by contacting Customer Service.

4.14.2 Use of Out-of-Network Pharmacies

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

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

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

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

4.14.3 Prescription Drug Formulary

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

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

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

Newly approved FDA drugs will be reviewed by the Oregon Region Pharmacy and Therapeutics Committee for safety and Medical Necessity within 12 months after the drug becomes available on the market. In the case of an urgent situation, we will authorize the use of a newly approved FDA drug during our review period so a Member does not go without Medically Necessary treatment.

To access the formulary for your plan, visit https://healthplans.providence.org/members/pharmacy-resources/.

4.14.4 Prescription Drugs

Generic and Brand-Name Prescription Drugs

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

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

Affordable Care Act Preventive Drugs

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

4.14.5 Prescription Drug Quantity

Prescription dispensing limits, including refills, are as follows:

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

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

4.14.6 Participating Mail-Order and Preferred Retail Pharmacies

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

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

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

4.14.7 Prescription Drug Limitations

Prescription drug limitations are as follows:

1. All drugs must be Food and Drug Administration (FDA) approved, Medically Necessary and require by law a prescription to dispense. Not all FDA-approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety and Medical Necessity within 12 months after the drug becomes available on the market for Formulary consideration.
2. Certain drugs require Prior Authorization for Medical Necessity, place of therapy, length of therapy, step therapy, number of doses or dispensing limits. Step therapy uses our pharmacy claims history to confirm if certain drugs have been tried first by a Member. If a drug has not been tried first, cannot be tried first, or if the drug history is not available, Prior Authorization is required. For some drugs, we limit the amount of the drug we will cover. You or your Qualified Practitioner can contact us directly to request Prior Authorization. If you have questions regarding a specific drug, please call Customer Service.

3. Specialty drugs are injectable, infused, oral, topical, or inhaled therapies that often require specialized delivery, handling, monitoring and administration and are generally high cost. These drugs must be purchased through our designated specialty pharmacy. Due to the nature of these medications, specialty drugs are limited to a 30-day supply. Specialty drugs are listed in our Formulary. In rare circumstances specialty medications may be filled for greater than a 30-day supply; in these cases, additional specialty cost share(s) may apply.
4. Self-injectable medications are only covered when they are being self-administered and labeled by the FDA for self-administration; in some cases, a Prior Authorization may be required for the drug. Documentation of self-administration may also be required. Drugs labeled for self-administration that are being administered by a provider will fall to the Member's medical benefit.
5. Compound prescription drugs must contain at least one ingredient that is an FDA-approved prescription drug in a therapeutic amount, must meet our Medical Necessity criteria and must be purchased at a Participating Pharmacy. Compounded drugs from bulk powders that are not a component of an FDA-approved drug are not covered. Claims are subject to clinical review for Medical Necessity and are not guaranteed for payment.
6. In accordance with the Affordable Care Act (ACA), your Plan covers, at no cost to you, certain preventive medications, including contraceptives, both prescription and Over-the-counter, when these medications are purchased from Participating Pharmacies. Not all preventive medications are required to be covered in full though. The ACA allows plans to use reasonable medical management to select medications that are covered in full (for example, when there is a generic medication available, the brand name may not be covered in full). If your Provider does not feel that the medications covered in full by your Plan are not the right ones for you, you may request coverage for a similar medication at $0 Cost-Share by submitting a Prior Authorization.
7. Vacation supply overrides are limited to a 30-day supply once per Calendar Year. Additional exceptions may be granted on a case-by-case basis.
8. A 30-day supply override will be granted if you are out of medication and have not yet received your drugs from a Participating mail-order Pharmacy.

4.14.8 Prescription Drug Benefit Exclusions

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

1. Drugs or medicines delivered, injected or administered to you by a physician or other provider or another trained person (these types of drugs are covered according to section 4.3.5);
2. Drugs prescribed that do not relate to the prevention or treatment of a covered illness or injury;
3. Drugs used for the treatment of fertility/infertility, except when used in the treatment of Fertility Preservation for oncological conditions as outlined in section 4.12.15;
4. Fluoride, for Members over 16 years of age;
5. Drugs that are not provided in accordance with our Formulary management program or are not provided according to our medical policy;
6. Drugs used in the treatment of fungal nail conditions;
7. Over-the-counter (OTC) drugs or vitamins, that may be purchased without a provider's written prescription, except as required by federal or Oregon state law;
8. Prescription drugs, including prescription combination drugs, that contain OTC products or are available in an OTC therapeutically similar form;

9. Drugs dispensed from pharmacies outside the United States, except when prescribed for Urgent Care and Emergency Medical Conditions or as required by federal or Oregon state law;
10. Drugs, which may include prescription combination drugs, placed on a prescription-only status as required by state or local law;
11. Replacement of lost, stolen, or damaged medication;
12. Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy's standard packaging for the place of service submitted;
13. Drugs or medicines used to treat sexual dysfunction (this exclusion does not apply to Mental Health Covered Services);
14. Drugs dispensed or compounded by a pharmacist that do not have at least one FDA-approved medication in therapeutic amount;
15. Drugs used for weight loss of for cosmetic purposes;
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. Prenatal vitamins that contain docosahexaenoic acid (DHA);
18. Drugs that are not FDA-approved or are designated as "less than effective" by the FDA (also known as "DESI" drugs);
19. Vaccines and medications solely for the purpose of preventing travel related diseases, as defined by the CDC;
20. Early refill, except when there is a change in directions or if synchronizing your prescription refills. This exclusion does not apply to eye drops prescribed for the treatment of glaucoma; and
21. For drugs obtained at in-network pharmacies without using your pharmacy benefit, reimbursement is limited to our in-network contracted rates, except in the case of Urgent/Emergent situations. This means you may not be reimbursed the full cash price you pay to the pharmacy. Drugs obtained from out-of-network pharmacies are not eligible for reimbursement, except in the case of Urgent/Emergent situations.

4.14.9 Prescription Drug Disclaimer

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

4.15 PEDIATRIC VISION SERVICES

This Contract provides coverage for routine Pediatric Vision Services for Members under age 19. Coverage is provided, as shown in your Benefit Summary. Pediatric Vision Services end on the last day of the month of the Member's 19th birthday.

<u>Pediatric vision exclusions:</u>

- Two pairs of glasses instead of bifocals;
- Replacement of lenses, frames or contacts;
- Medical or surgical treatment;
- Supplemental testing and vision training, except as provided in section 4.12.16;
- Contact lens insurance policies and service agreements;
- Artistically painted or non-prescription contact lenses;
- Additional office visits for contact lens pathology; and
- Contact lens modification, polishing or cleaning.

4.16 ADULT VISION SERVICES

The Plan provides coverage for routine Adult Vision Services for Members age 19 and over. Coverage is provided, as shown in your Benefit Summary.

<u>Adult vision exclusions:</u>

- Two pairs of glasses instead of bifocals;
- Replacement of lenses, frames or contacts;
- Medical or surgical treatment;
- Supplemental testing and vision training, except as provided in section 4.12.16;
- Contact lens insurance policies and service agreements;
- Artistically painted or non-prescription contact lenses;
- Additional office visits for contact lens pathology; and
- Contact lens modification, polishing or cleaning.

4.17 PEDIATRIC DENTAL BENEFIT

The Pediatric Dental Benefit provides coverage for routine Dental Services for Members under age 19. See your Pediatric Dental Benefit Summary for a description of your Pediatric Dental Benefit, Covered Services and Limitations. The Pediatric Dental Benefit ends on the last day of the month of the Member's 19th birthday.

<u>Pediatric Dental Limitations</u>
<u>Class I. Diagnostic and Preventive Services:</u>

- Two evaluations (D0120, D0145, D0150, D0160, or D0180) per 12 months' coverage for all evaluations by medical practitioners who are oral surgeons;
- One limited evaluation or re-evaluation, problem focused (D0140 or D0170) do not count against annual exam frequency limitation;
- One prophylaxis (D1110 or D1120) per six months;
- One fluoride treatment per six months (additional topical fluoride treatments may be available when high risk conditions or oral health factors are present);
- Four bitewing x-rays per six months;
- Periapical x-rays, limited to six films per 12 months for Members under age six (not on the same date of service as a panoramic radiograph);
- One full mouth x-ray or panoramic film (starting at age six) per 36 months; maximum of one set of x-rays per office visit;
- Covers fixed and removable space maintainers to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment); recementation of space maintainer; removal of fixed space maintainer (cannot be billed by the provider or practice that placed the appliance);
- One sealant per tooth per 60 months, (limited to occlusal surfaces of posterior permanent teeth without restorations or decay);
- One interim caries arresting medicament application per primary tooth is covered per lifetime;
- Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service); and
- Two pre-diagnostic assessments of patient (D0191) per 12 months.

Class II. Basic Services:

- Amalgam and composite fillings (restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), includes occlusal adjustment and polishing of restoration; sedative fillings when not billed on the same day of normal restoration;
- Pin retention of fillings (multiple pins on the same tooth are allowable as one pin); and
- General anesthesia and analgesic (only when provided in connection with a covered periodontal and oral surgery procedure(s) when determined to be medically or dentally necessary for documented handicapped or uncontrollable Members or justifiable medical or dental conditions).

Class III. Major Services:

- Oral surgery, including postoperative care for:
    - Removal of teeth except the surgical removal of 3rd molars includes local anesthesia and routine postoperative care, including treatment of a dry socket if done by the provider of the extraction (surgical removal of impacted teeth or removal of residual tooth roots limited to teeth that have acute infection or abscess, severe tooth pain, and/or unusual swelling of the face of gums);
    - Extraction of tooth root or partial tooth;
    - Coronectomy, intentional partial tooth removal;
    - Alveolectomy, alveoplasty, frenectomy, frenuloplasty and vestibuloplasty;
    - Excision of periocoronal gingiva or hyper plastic tissue;
    - Excision of oral tissue for biopsy;
    - Tooth reimplantation and/or stabilization; tooth transplantation
    - Excision of a tumor or cyst and incision and drainage of an abscess or cyst; and
    - Biopsy or oral tissue (D7285, D7286).
- Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
    - Root canal therapy once per lifetime, per permanent tooth (not covered for third molars);
    - Retreatment of previous root canal therapy, on anterior teeth, one per lifetime, not within 24 months when done by same dentist or dental office;
    - Pulp cap;
    - Pulpotomy and pulpal debridement;
    - Pulpal therapy and regeneration;
    - Apexification/recalcification (endodontists only);
    - Apicoectomy; and
    - Retrograde fillings.
- Periodontic Services, limited to:
    - One periodontal cleaning following periodontal therapy (surgical or non-surgical) that is documented to have occurred within the past three years, per six months;
    - One root scaling and planing, once per 24 months per quadrant;
    - Scaling in presence of generalized moderate or severe gingival inflammation, full mouth, after oral evaluation in lieu of a covered D1120/D1110, limited to once per two years;

- Gingivectomy/gingivoplasty (D4210/D4211), limited to coverage for severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to oral hygiene procedures;
  - Osseous surgery including flap entry and closure, once per quadrant
  - One pedicle, free soft tissue, subepithelial connective tissue or double pedicle graft per site, per lifetime; and
  - One full mouth debridement per 24 months.
- Restoration Services, limited to:
  - Cast metal, stainless steel, resin-based, gold or porcelain/ceramic inlay, onlay, and crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling; permanent crown replacement limited to once every seven years and all other crown replacements limited to once every five years; stainless steel crowns (D2930/D2931) allowed only for anterior primary and posterior permanent or primary teeth; prefabricated stainless steel crowns (D2933) allowed only for anterior teeth; permanent and porcelain fused to metal crowns limited to teeth numbers 6-11, 22 and 27 only (members age 16 and under 19; includes preparation of gingival tissue);
    - If a Member chooses a crown other than defined above, coverage will be paid for the least costly Dentally Necessary Service. If a Member elects a more costly option, the Member will be responsible for the difference in cost.
  - Recementing and repair of crowns, dentures and bridges;
  - Post removal; and
  - Crown build-up for non-vital teeth.
- Prosthetic Services, limited to:
  - Initial placement of dentures; members age 16 and older are eligible for removable resin base partial dentures (D5211-D5212) and full denture (complete or immediate, D5110-D5140); includes adjustments during six-month period following delivery;
  - Repair of dentures;
  - Replacement of removable partial or full dentures that cannot be repaired for Members at least 16 and under 19, shall replace after ten years for full dentures and after five years for partial dentures from the date of last placement; interim partial dentures and flippers (D5820-D5821) covered if the Member has one or more anterior teeth missing and are covered once per five years when dentally appropriate;
  - One relining or rebasing of existing removable dentures or rebonding/recementing fixed dentures per 36 months (only after six months from date of last placement, unless an immediate prosthesis replacing at least three teeth); laboratory relines are not covered prior to six months after placement of an immediate denture and are limited to once per 36 months; rebases covered only if a reline may not adequately solver the problem; exceptions to this limitation may be made in the event of acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This includes, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical and/or medical treatment for these conditions (severe periodontal disease due to neglect of daily oral hygiene may not warrant rebasing);
  - Addition of teeth or clasp to existing partial denture;
  - Construction and repair of bridges, replacement limited to once per 60 months;

  - Fluoride gel carrier for patients with severe oral disease;
  - Tissue conditioning (not covered when performed within 6 months of any denture); and
  - Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year.

Pediatric Dental Exclusions

- Oral surgery requiring the setting of fractures or dislocations;
- Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development of malformations where such services should not be performed in a dental office;
- Dispensing of drugs;
- Hospitalization for any dental procedure;
- Replacement due to loss or theft of prosthetic appliance;
- Services to treat temporomandibular joint syndrome;
- Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth. The prophylactic removal of these teeth for Medically Necessary orthodontia services may be covered subject to review;
- Replacement of dentures, inlays, onlays or crowns that can be repaired to normal function;
- Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions except if the developmental malformation and or congenital conditions cause severe, dysfunctional handicapping malocclusion that requires Medically Necessary orthodontia services;
- Experimental/Investigational procedures;
- Treatment of cleft palate, malignancies or neoplasms (see your medical benefits and section 4.12.6 for coverage of these conditions); and
- Orthodontics (see your medical benefits and section 4.12.6 for coverage of Medically Necessary orthodontics to treat craniofacial anomalies.

5. EXCLUSIONS

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

<u>General Exclusions:</u>

We do not cover Services and supplies which:

- Are not provided;
- Are provided without charge or for which you would not be required to pay if you did not have this coverage;
- Are received before the Effective Date of Coverage;
- Are not a Covered Service or relate to complications resulting from a Non-Covered Service, except for Services provided as Emergency Care, as described in section 4.5;
- Are not furnished by a Qualified Practitioner or Qualified Treatment Facility;
- Are provided by or payable under any health plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law;
- Are provided while you are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies, except to the extent provided by 38 U. S. C. § 1729 as it relates to non-military Services provided at a Veterans Administration Hospital or facility;
- Are provided while you are in the custody of any law enforcement authorities or while incarcerated, except as provided in section 3.3;
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos, books and educational programs to which drivers are referred by the judicial system and volunteer mutual support groups;
- Are provided to yield primarily educational outcomes, except 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 Contract, except Emergency Services;
- Are provided for any injury or illness that is sustained by any Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the Member. This exclusion also applies to injuries and illnesses that are the subject of a claim settlement where medical coverage is inclusive of and provided for under the terms of the settlement, such as a claim disposition agreement, applicable under a Workers' Compensation Act or similar law. This exclusion does not apply to Members who are exempt under any Workers' Compensation Act or similar law;
- Are payable under any automobile medical, personal injury protection ("PIP"), automobile no-fault, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance makes benefits or Services available to you, whether or not you make application for such benefits or Services and whether or not you are refused payment for failure to satisfy any term of such coverage. If such coverage is required by law and you unlawfully fail to obtain it, benefits will be deemed to have been payable to the extent of that requirement. This

exclusion also applies to charges applied to the Deductible of such contract or insurance. Any benefits or Services provided under this Contract that are subject to this exclusion are provided solely to assist you and such assistance does not waive our right to reimbursement or subrogation as specified in section 6.3. This exclusion also applies to Services and supplies after you have received proceeds from a settlement as specified in section 6.3.3;

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

We do not cover:

- Charges that are in excess of the Usual, Customary and Reasonable (UCR) charges;
- Custodial Care;
- Transplants, except as provided in section 4.13;
- Services for Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices and Durable Medical Equipment (DME), except as described in section 4.9;
- Charges for Services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to, air conditioners, air purifiers, vacuum cleaners, motorized transportation equipment, escalators, elevators, tanning beds, ramps, waterbeds, hypoallergenic mattresses, cervical pillows, swimming pools, whirlpools, spas, exercise equipment, gravity lumbar reduction chairs, home blood pressure kits, personal computers and related equipment or other similar items or equipment;
- Physical therapy, rehabilitative and habilitative services, except as provided in sections 4.6.3, 4.6.4, 4.7.2 and 4.7.3;
- "Telephone visits" by a physician or "environment intervention" or "consultation" by telephone for which a charge is made to the patient, except as provided in section 4.3.2;
- "Get acquainted" visits without physical assessment or diagnostic or therapeutic intervention provided and online treatment sessions;
- Missed appointments;
- Non-emergency medical transportation, except as provided in section 4.5.1;
- Allergy shots and allergy serums, except as provided in section 4.3.5;

- All Services and supplies related to the treatment of obesity or morbid obesity, except as provided in section 4.1;
- Services for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas, except as provided in section 4.1;
- Transportation or travel time, food, lodging accommodations and communication expenses, except as provided in sections 3.7 and 4.13 and with our prior approval;
- Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
- Massage therapy;
- Biofeedback, except as provided in section 4.12.8;
- Thermography;
- Homeopathic procedures;
- Comprehensive digestive stool analysis, cytotoxic food allergy test, dark-field examination for toxicity or parasites, EAV and electronic tests for diagnosis and allergy, fecal transient and retention time, Henshaw test, intestinal permeability, Loomis 24-hour urine nutrient/enzyme analysis, melatonin biorhythm challenge, salivary caffeine clearance, sulfate/creatinine ratio, urinary sodium benzoate, urine/saliva pH, tryptophan load test, and zinc tolerance test;
- Chiropractic manipulation and acupuncture, except as provided in sections 4.12.13 and 4.12.14;
- Light therapy for seasonal affective disorder, including equipment;
- Any vitamins, dietary supplements, and other non-prescription supplements, except as required by federal or Oregon state law;
- Services for genetic testing are excluded, except as provided in section 4.12.1. Genetic testing is not covered for screening, to diagnose carrier states, or for informational purposes in the absence of disease;
- Services to modify the use of tobacco and nicotine, except as provided in section 4.1.8 or when provided as Extra Values or Discounts (see our website at ProvidenceHealthPlan.com), where available;
- Cosmetic Services including supplies and drugs, except as approved by us and described in section 4;
- Services, including routine physical examination, immunizations and vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel;
- Non-sterile examination gloves;
- Sales taxes, handling fees and similar surcharges, as explained in the definition of UCR;
- Air ambulance transportation for non-emergency situations is not covered, except as provided in section 4.5.2;
- Services provided under a court order or as a condition of parole or probation or instead of incarceration which are not Medically Necessary;
- Personal growth services such as assertiveness training or consciousness raising;
- School counseling and support services, peer support services, tutor and mentor services, independent living services, household management training and wraparound services that are provided by a school or halfway house and received as part of an education or training program;

- Recreation services, therapeutic foster care, wraparound Services; emergency aid for household items and expenses; services to improve economic stability and interpretation services;
- Evaluation or treatment for education, professional training, employment investigations and fitness for duty evaluations;
- Community care facilities that provide 24-hour non-medical residential care;
- Speech therapy, physical therapy and occupational therapy services provided in connection with treatment of psychosocial speech delay, learning disorders, including intellectual disability and motor skill disorders, and educational speech delay including delayed language development (except as provided in sections 4.6.3, 4.6.4, 4.7.2 and 4.7.3);
- Counseling related to family, marriage, sex and career including, but not limited to, counseling for adoption, custody, family planning or pregnancy, in the absence of a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis;
- Neurological Services and tests including, but not limited to, EEGs; PET, CT, MRA and MRI imaging Services; and beam scans (except as provided in section 4.4.1);
- Vocational, pastoral or spiritual counseling;
- Viscosupplementation (i.e., hyaluronic acid/hyaluronan injection);
- All Direct-to-Consumer testing products; and
- Dance, poetry, music or art therapy, except as part of an approved treatment program.

Exclusions that apply to Provider Services:
- Services of homeopaths; faith healers; or lay, unlicensed direct entry, and certified professional midwives; and
- Services of any unlicensed providers.

Exclusions that apply to Reproductive Services:
- All services related to sexual disorders or dysfunctions regardless of gender or cause. This exclusion does not apply to Mental Health Covered Services;
- All of the following services, except as described in section 4.12.15:
  - All services related to surrogate parenting, except Maternity Services, as described in section 4.8;
  - All services related to in vitro fertilization, including charges for egg/semen harvesting and storage;
  - All services related to artificial insemination, including charges for semen harvesting and storage;
  - All services and prescription drugs related to Fertility Preservation;
  - Diagnostic testing and associated office visits to determine the cause of infertility;
  - All of the following services when provided for the sole purpose of diagnosing and treating an infertile state or artificial reproduction:
    - Physical examination;
    - Related laboratory testing;
    - Instruction;
    - Medical and surgical procedures, such as hysterosalpingogram, laparoscopy, or pelvic ultrasound; and

        - Related supplies and prescriptions.

  For the purpose of this exclusion:
    - Infertility or infertile means the failure to become pregnant after a year of unprotected intercourse or the failure to carry a pregnancy to term as evidenced by three consecutive spontaneous abortions;
    - Artificial reproduction means the creation of new life other than by the natural means;
- Termination of pregnancy, unless there is a severe threat to the mother, or if the life of the fetus cannot be sustained;
- Reversal of voluntary sterilization; and
- Services provided in a premenstrual syndrome clinic or holistic medicine clinic.

Exclusions that apply to <u>Vision Services</u>:
- 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; and
- Services for routine eye care and vision care, vision exams/screenings, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in sections 4.1.1, 4.1.5, 4.5.3, 4.9.2, 4.15 and 4.16.
- Orthoptics and vision training, except as provided in section 4.12.16.

Exclusions that apply to <u>Hearing Services</u>:
- Hearing aids, hearing therapies and/or devices, including all services related to the examination and fitting of the Hearing Aids, except as provided in section 4.12.11.

Exclusions that apply to <u>Dental Services</u>:
- Oral surgery (non-dental or dental) or other dental services (all procedures involving the teeth, wisdom teeth, areas surrounding the teeth, and dental implants), except as stated in sections 4.12.6;
- Services for orthognathic surgery, except as approved by us and described in section 4.12.6;
- Services to treat temporomandibular joint syndrome (TMJ);
- Dentures and orthodontia; except as provided in sections 4.12.6; and
- Services for routine dental care, dental exams/screenings, and repair, except as provided in section 4.17.

Exclusions that apply to <u>Foot Care Services</u>:
- Routine foot care, such as removal of corns and calluses, except for Members with diabetes; and
- Services for orthotics, insoles, arch supports, heel wedges, lifts and orthopedic shoes, except as described in section 4.9.2.

Exclusions that apply to Prescription Drugs, Medicines and Devices:
- Outpatient prescription drugs, medicines and devices, except as provided in sections 4.2.4, 4.12.7 and 4.14; and
- Any drug, medicine, or device that does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Pre-market Approval, or 510K.

6. CLAIMS ADMINISTRATION

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

6.1 CLAIMS PAYMENT

Our payments for most Services are made directly to the providers of Services. Except as otherwise specifically provided in this Contract, if you are billed directly and pay for benefits which are covered by this Contract, reimbursement from us will be made only upon your written notice to us of the payment. Payment will be made to the Policyholder, subject to written notice of claim, or, if deceased, to the Policyholder's estate, unless payment to other parties is authorized in writing by you.

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

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

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

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

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

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

Claims Involving Concurrent Care Decisions

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

6.1.1 Timely Submission of Claims

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

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

Medical, Mental Health, and Substance Use Disorder claims:

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

Routine Vision claims:

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

Pediatric Dental Benefit claims:

Dental Processing Center, Inc.
P.O. Box 211424
Eagan, MN 55121

6.1.2 Right of Recovery

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

6.2 COORDINATION OF BENEFITS

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

6.2.1 Definitions Relating to Coordination of Benefits

Plan

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

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

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

This Plan

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

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

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

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

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

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

<u>Closed panel plan</u>
A Closed panel plan is a Plan that provides health care benefits to Members. These benefits are primarily in the form of Services through a panel of providers. These providers have been contracted with or employed by the Plan. Coverage for services provided by other providers is excluded. Exceptions will only be made in cases of emergency or if there is referral by a panel member.

Custodial parent

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

6.2.2 Order of Benefit Determination Rules

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

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

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

C. Each Plan determines its order of benefits using the first of the following rules that apply:
   1. Non-Dependent or Dependent. The Plan that covers a Member other than as a Dependent, for example, as an employee, Subscriber or retiree is the Primary plan and the Plan that covers the Member as a Dependent is the Secondary plan. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Member as a Dependent; and primary to the Plan covering the Member as other than a Dependent (e.g., a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Member as an employee, Subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
   2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Member is a Dependent child covered by more than one Plan the order of benefits is determined as follows:
      a) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
         i. The Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary plan; or
         ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
      b) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
         i. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of

those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

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

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

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

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

d) For a Dependent child:

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

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

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

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

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

6.2.3 Effect on the Benefits of This Plan

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

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

6.2.4 Right to Receive and Release Needed Information

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

6.2.5 Facility of Payment

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

6.2.6 Right of Recovery

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

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

6.2.7 Medicare Non-Duplication of Coverage

If you are entitled to Medicare benefits and are covered under this Contract at the same time, Medicare is primary and we are secondary.

- If the total reimbursement from Medicare, including amounts applied toward any Deductible, is less than, equals or exceeds the benefits payable under this Contract, then no additional payment will be made by us.
- If you are entitled to Medicare Part A, we assume you have enrolled in Medicare Part B and we will not provide benefits for any part of a Service that would have been paid for under Medicare Part B had you enrolled.

6.3 THIRD-PARTY LIABILITY/SUBROGATION

The following provisions will apply when you or any other Member has received Services for a condition for which one or more third parties may be responsible. “Third party” means any person other than the Member (the first party to the provisions of this Contract), and Providence Health Plan (the second party), and includes any insurance carrier providing liability or other coverage potentially available to the Member. For example, uninsured or underinsured motorist coverage, no-fault medical payments (auto, homeowners or otherwise), or other individual or group insurance (including student plans) whether under the Member’s policy or not, are subject to recovery by us as a third-party recovery. Failure by the Member to comply with the terms of this section will be a basis for us to deny any claims for benefits arising from the condition or to terminate the Member’s coverage under this Contract as specified in section 9.4. In addition, you or the Member must execute and deliver to us and to other parties any document requested by us which may be appropriate to confirm or secure the rights and obligations of the Member and Providence Health Plan under these provisions.

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

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

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

“Subrogation” means that we may collect directly from the third party to the extent we have paid for third-party liabilities. Because we have paid for the Member’s injuries, we, rather

than the Member, are entitled to recover those expenses. Prior to accepting any settlement of the Member's claim against a third party, the Member must notify us in writing of any terms or conditions offered in settlement and must notify the third party of our interest in the settlement established by this provision.

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

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

6.3.2 Proceeds of Settlement or Recovery

Subject to paragraph 6.3.4 below, if for any reason we are not paid directly by the third party, we are entitled to reimbursement from the Member or the Member's heirs, legal representatives, beneficiaries or relatives, and we may request refunds from the medical providers who treated the Member, in which case those providers will bill the Member for their Services. To the fullest extent permitted by law, we are entitled to the proceeds of any settlement, award, verdict, or other payment that results in a monetary recovery from a third party, whether or not responsibility is accepted or denied by the third party for the condition, whether or not such monetary recovery is described by any person as something other than a recovery of medical expenses incurred by us, and whether or not the Member is alleged to have any fault, under principles of comparative negligence or otherwise. With respect to any workers' compensation recovery, we are entitled to the proceeds whether or not the loss is deemed to be compensable under the workers' compensation laws. We are entitled to recover up to the full value of the benefits provided by us for the condition, calculated using our UCR charges for such Services, less our pro rata share of the Member's out-of-pocket expenses and attorney fees incurred in making the recovery. We are entitled to such recovery regardless of whether the Member has been fully compensated or "made whole" for the loss caused by the third party, and regardless of whether the Member has been partially compensated for such loss. We are entitled to first priority in repayment, over the Member and over any other person, for such charges.

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

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

6.3.3 Suspension of Benefits and Reimbursement

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

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

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

6.3.4 Special Rules for Motor Vehicle Accident Cases

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

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

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

7. PROBLEM RESOLUTION

7.1 INFORMAL PROBLEM RESOLUTION

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

7.2 MEMBER GRIEVANCE AND APPEAL

Definitions:

Adverse Benefit Determination

An Adverse Benefit Determination means a:

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

Appeal

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

Authorized Representative

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

Concurrent Care

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

Grievance

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

- In writing, for an internal Appeal or an external review; or in writing or orally, for an expedited response or an expedited external review; or
- A written complaint submitted by a Member or an Authorized Representative of a Member regarding the:
    - Availability, delivery or quality of a health care service;

- Claims payment, handling or reimbursement for health care services and, unless the Member has not submitted a request for an internal Appeal, the complaint is not disputing an Adverse Benefit Determination; or
- Matters pertaining to the contractual relationship between a Member and Providence Health Plan.

7.2.1 Your Grievance and Appeal Rights

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

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

Request for Claim/Appeal File and Additional Information:

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

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

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

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

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

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

7.2.2 Internal Grievance or Appeal

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

7.2.3 External Review

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

If you request an external review you must agree to authorize release of medical records needed by the IRO and submit any additional information to the IRO no later than five days after the appointment of the IRO, or 24 hours in cases of expedited review. The IRO is entirely independent of Providence Health Plan and performs its review under a contract with the Oregon Division of Financial Regulation. The IRO will notify you and us of its decision within three days for expedited reviews and within 30 days when not expedited. **We agree to be bound by and to comply with the IRO decision.**

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

7.2.4 Information Available Upon Request

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

7.2.5 How to Submit Grievances or Appeals and Request Appeal Documents

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

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

You may fax your Grievance or Appeal to 503-574-8757 or 800-396-4778, or you may hand deliver it (*if mailing, use only the post office box address listed above*) to the following address:

Providence Health Plan
3601 SW Murray Blvd., Ste. 10
Beaverton, OR 97005

7.2.6 Assistance with your Grievance or Appeal

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

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

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

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

8. ELIGIBILITY, ENROLLMENT, PREMIUMS AND TERMINATION

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

8.1 POLICYHOLDER ELIGIBILITY AND ENROLLMENT

8.1.1 Eligibility Requirements

An individual is eligible for coverage as a Policyholder when:

1. The individual has applied for coverage by enrolling:
    - Directly with Providence Health Plan by completing and submitting to Providence Health Plan our Individual Application; or
    - In the Exchange Market by completing the online application at HealthCare.gov;
2. The individual resides in our Service Area, as stated in section 13;
3. The individual is not entitled to Medicare Part A and/or enrolled in Medicare Part B; and
4. The individual has been approved by Providence Health Plan or HealthCare.gov for enrollment.

8.1.2 Open Enrollment and Effective Date of Coverage

This Plan has an annual Open Enrollment period.

To request coverage, an Eligible Individual must apply with Providence Health Plan by completing our Individual Application, or enrolling online at HealthCare.gov during Open Enrollment. The Open Enrollment period is November 1st through December 31st, with coverage effective January 1st of the following Calendar Year. You may also apply from January 1st through January 15th for a February 1st effective date.

To be eligible for an offer of coverage, by the last day of the Open Enrollment Period:

- Providence Health Plan must receive your completed Individual Application: or
- You must submit an application online through HealthCare.gov.

In order for coverage to become effective, Providence Health Plan must receive your initial month's Premium in full within 15 days after the Effective Date of Coverage, or within 30 days after the date of our written confirmation of your acceptance for coverage and notice of initial Premium, whichever is later.

If your initial month's Premium is not received within 15 days after the Effective Date of Coverage, or within 30 days after the date of our written confirmation of your acceptance for coverage and notice of initial Premium, whichever is later, your application and our offer of coverage are void.

For enrollment outside of Open Enrollment, see section 8.4 Special Enrollment.

8.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

8.2.1 Eligibility Requirements

Each Dependent is eligible for coverage as an Eligible Family Dependent when:

1. The Dependent has applied for coverage by enrolling:
    - Directly with Providence Health Plan by completing and submitting to Providence Health Plan our Individual Application; or
    - In the Exchange Market by completing the online application at HealthCare.gov;
2. The Dependent resides in our Service Area, as stated in section 13 (this requirement applies to Spouses and to individuals enrolling in Child-only coverage);
3. The Dependent is not entitled to Medicare Part A and/or enrolled in Medicare Part B; and
4. The Dependent has been approved by Providence Health Plan or HealthCare.gov for enrollment.

See section 8.3 for eligibility requirements for newborn, newly adopted children, and newly fostered children of existing Members.

8.2.2 Enrollment and Effective Date of Coverage when Applying During Open Enrollment

To obtain coverage, an Eligible Family Dependent must enroll with Providence Health Plan by completing our Individual Application or by enrolling online at HealthCare.gov during Open Enrollment. The Open Enrollment period is November 1st through December 31st, with coverage effective January 1st of the following Calendar Year. You may also apply from January 1st through January 15th for a February 1st effective date.

To be eligible for an offer of coverage, by the last day of the Open Enrollment Period:

- Providence Health Plan must receive your completed Individual Application; or
- You must submit an application online through HealthCare.gov.

In order for coverage to become effective, Providence Health Plan must receive your initial month's Premium in full within 15 days after the first day of the Plan Year, or within 30 days after the date of our written confirmation of your acceptance for coverage and notice of initial Premium, whichever is later.

If your initial month's Premium is not received within 15 days after the beginning of your Plan Year, or within 30 days after the date of our written confirmation of your acceptance for coverage and notice of initial Premium, whichever is later, your application and our offer of coverage are void.

See section 8.3 for Enrollment and Effective Date of Coverage requirements for newborn, newly adopted children, and newly fostered children of existing Members.

8.3 NEWBORN, NEWLY ADOPTED CHILDREN, AND NEWLY FOSTERED CHILDREN ELIGIBILITY AND ENROLLMENT

A newborn, newly adopted child, or newly fostered child of an existing Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption or foster care, if the newborn, newly adopted child, or newly fostered child is enrolled and the additional Premium is paid to us within 60 days of the date of birth or placement for adoption or foster care. If the enrollment and payment of the additional Premium due is not accomplished within this time period, no medical Services will be covered for the child. Enrollment after this period is subject to the requirements stated in sections 8.2.

8.4 SPECIAL ENROLLMENT

Providence Health Plan and HealthCare.gov will accept applications for coverage outside of Open Enrollment if the applicant has experienced a Qualifying Event.

Qualifying Events:

a) The person loses minimum essential coverage:
   - The person was covered under a COBRA Continuation or State Continuation provision and the coverage under such a provision was exhausted, except when the person failed to pay timely premium, or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact); or
   - The person was covered under a group health plan, individual health plan or other health coverage and the coverage was terminated as a result of:
     1. The person's loss of eligibility for the coverage; including as a result of legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment; except when the person failed to pay timely premium or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact); or
     2. The person's loss of eligibility for coverage under the Children's Health Insurance Program (CHIP), Medicaid, Medicare, TRICARE, Indian Health Service or domestic or foreign publicly sponsored or subsidized health plan; including, but not limited to, the Oregon Health Plan (OHP) or Qualified Health Plan coverage through the Oregon Health Insurance Marketplace through the Federal Exchange; or
     3. The termination of contributions toward such coverage by the current or former Employer; or
     4. The person incurring a claim that exceeds the lifetime limit on benefits.

b) The person previously resided outside of our Service Area and has moved into our Service Area and was covered under another group health plan, individual health plan or other health coverage for at least one day in the previous 60 days.
   - Exceptions to the 60-day requirement:
     1. The person moves from out of country back to the United States of America; or
     2. The person gains status as a lawfully present individual or United States citizen; or
     3. The person is released from incarceration.

c) The person gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption or foster care.

d) The person becomes eligible for coverage under a state-sponsored or federal-sponsored premium assistance program.

e) The person is subject to a Qualified Medical Child Support Order or other court order requiring medical coverage.

f) The person is a survivor of domestic abuse/violence or spousal abandonment and wants to enroll in a health plan separate from the abuser or abandoner.

g) The person newly gains access to an individual coverage HRA (ICHRA) or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA).

h) Additional Special Enrollment Period rights are available to American Indians or Alaska Natives.

HealthCare.gov will allow a person to qualify during a Special Enrollment Period for certain other life events. For a full list of life events, please visit HealthCare.gov.

Providence Health Plan or HealthCare.gov may modify Special Enrollment provisions consistent with federal or state guidance.

8.4.1 Special Enrollment and Effective Date of Coverage

Special Enrollment through Providence Health Plan:

To obtain coverage due to a Special Enrollment Qualifying Event through Providence Health Plan, your application for coverage must be received within 60 days of the Qualifying Event. The Effective Date of Coverage is determined by the Qualifying Event, the date your completed application is received, as well as Providence Health Plan's timely receipt of your initial Premium.

- When the Qualifying Event is birth, adoption, placement for adoption or foster care of a child or court order, coverage will be effective from date of birth, placement or court order, provided your completed application and initial Premium payment are received within 60 days of birth, placement or court order.
- For all other Qualifying Events, coverage will be effective the first day of the month following Providence Health Plan's receipt of your completed application, upon timely receipt of your initial Premium payment.

In order for coverage to become effective, Providence Health Plan must receive your initial month's Premium in full within 15 days after the Effective Date of Coverage, or within 30 days after the date of our written confirmation of your acceptance for coverage and notice of initial Premium, whichever is later.

If your initial month's Premium is not received within 15 days after the Effective Date of Coverage, or within 30 days after the date of our written confirmation of your acceptance for coverage and notice of initial Premium, whichever is later, your application and our offer of coverage are void.

Special Enrollment through HealthCare.gov:

To obtain coverage due to a Special Enrollment Qualifying Event through HealthCare.gov, you must submit your application for coverage to HealthCare.gov within 60 days of the Qualifying Event.

- When the Qualifying Event is birth, adoption, placement for adoption, foster care or court order, coverage will be effective from date of birth, placement or court order provided the plan selection and initial Premium are received within 60 days of birth, placement or court order.
- For all other Qualifying Events, HealthCare.gov determines the effective date of coverage. Visit the HealthCare.gov website for additional information.

See section 8.3 for Enrollment and Effective Date of Coverage requirements for newborn, newly adopted children, and newly fostered children of existing Members.

8.5 CHANGE IN RESIDENT ADDRESS

Your eligibility for coverage is determined by your residence address (where you live). Providence Health Plan will only issue coverage to Policyholders, Spouses, and Members enrolled on Child-only plans who reside within our Service Area. The Service Area for this Plan is listed in section 13.

If a Policyholder, Spouse, or Member enrolled on a Child-only plan moves outside of the Service Area, that individual will no longer be eligible for coverage under this Plan. Providence Health Plan offers coverage throughout the state of Oregon and in certain counties in Washington. Should a Policyholder, Spouse, or Member enrolled on a Child-only plan move outside of the Service Area for this Plan, that individual may be eligible for coverage under a different plan offered by Providence Health Plan. Customer Service can assist someone who has experienced a move in determining eligibility.

Premiums may differ between counties within the Service Area for this Plan. If a Premium change occurs due to moving to a new county within the Service Area for this Plan, the new Premium amount will be effective the first of the month following the date of the move.

Policyholders enrolled through Providence Health Plan are responsible for communicating changes in residence address for themselves and all enrolled Family Members to Providence Health Plan in a timely manner. Failure to do so may result in termination of coverage, as discussed in section 9.4.

Policyholders enrolled through HealthCare.gov are responsible for communicating changes in residence address for themselves and all enrolled Family Members to HealthCare.gov in a timely manner. Failure to do so may result in termination of coverage, as discussed in section 9.4.

9. PREMIUM, RENEWAL, REVISION, TERMINATION AND RESCISSION

9.1 PREMIUMS

9.1.1 Premium Billing Information

Providence Health Plan will provide a Premium billing statement on a monthly basis to the Policyholder listing the amount of Premium due. If you choose to set up recurring monthly premium payments using the Providence Electronic Payment System, you will receive a monthly notice of the amount charged to your account.

9.1.2 Changes in Premium Charges

The Premium may be changed only in accordance with the following provisions or as directed by HealthCare.gov:

1. The Premium is subject to change upon renewal of this Contract for another Plan Year.
2. If at any time during a Plan Year any federal or state law or any order or regulation of a federal or state agency mandates a modification of benefits under this Contract, we may change the Premium and/or Covered Services accordingly and you will be notified of this change in writing. The change in Premium shall be effective on the effective date of the modification of benefits, as stated in the notice.
3. If at any time during a Contract Year any federal or state law enacts a tax or assessment associated with this Individual & Family Plan, Providence Health Plan may revise the Premium as necessary. The change in Premium shall be effective on the effective date of the tax or assessment, as stated in the notice.
4. The Premium may be adjusted to reflect a change in your circumstance, including changes in your residence address and changes in your family composition. The change in Premium shall be effective, as described in sections 8.3, 8.4 and 8.5.

9.1.3 Premium Payment Due Date

The Premium is due on the first of the month. If the Policyholder does not pay the Premium by the first of the month, the policy will be in a 30-day grace period. We will mail a single Premium delinquency notice to the Policyholder. If the Policyholder does not pay the Premium by the last day of the 30-day grace period, as specified in the notice, coverage will be terminated, with no further notice to the Policyholder. Failure to pay the Premium includes making a partial payment of the amount due as Premium. If we fail to send the Premium delinquency notice specified above, we will continue the Contract in effect, without payment of Premium, until we provide such notice.

For Policyholders enrolled directly with Providence Health Plan and for Policyholders enrolled through Healthcare.gov but are not receiving an Advance Premium Tax Credit (APTC), the effective date of termination will be the last day of the monthly period through which the Premium was paid in full.

For Policyholders enrolled through Healthcare.gov and are receiving APTC, your grace period is three consecutive months, as establishing by the Affordable Care Act. During the first month of the 3-month grace period, benefits will be in-force and claims will be paid for all Covered Services. During the second and third month of the 3-month grace period, claims are pended and will not be paid by Providence Health Plan unless all Premium amounts are received before the end of the three-month grace period.

The effective date of termination for Policyholders receiving APTC will be the last day of the first month of the 3-month grace period. If the Premium amount for the first month of the 3-month grace period is not received, the Policyholder may be subject to collections.

9.2 CHANGING PLANS

Members who wish to select a different plan option following enrollment may request a plan change during the annual Open Enrollment Period or during a Special Enrollment Period if you or a Family Member has experienced a Qualifying Event, as stated in section 8.4.

9.2.1 Combining Coverage Under One Plan

Family Members who are enrolled under separate Contracts may request to combine their coverage under one plan during the annual Open Enrollment Period or during a Special Enrollment Period if you or a Family Member has experienced a Qualifying Event, as stated in section 8.4.

9.3 RENEWAL AND REVISION

This Contract is guaranteed renewable and will not be terminated due to claims experience, health status, or length of time in force.

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

We may revise this Contract outside of renewal if required by federal or State mandate. To the extent permissible by such mandate, we will provide you with at least 30 days advance written notice of such revision.

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

9.4 TERMINATION

This Contract may be terminated for any of the following reasons:

1. When the Policyholder fails to pay the Premium by the due date as specified in section 9.1.3.
2. When the Policyholder makes a written request for termination of this Contract. The termination of coverage will be effective on the last day of the monthly period through which Premium was paid.
3. When a Policyholder, enrolled Spouse, or a Member enrolled in Child-only coverage ceases to reside in our Service Area, as described in section 13. The termination of coverage will be effective the last day of the month in which the Member resides in our Service Area.
4. When a Family Member no longer qualifies as an Eligible Family Dependent. The termination of coverage will be effective on the last day of the month in which the individual ceases to qualify as an Eligible Family Dependent.
5. Upon our discovery of fraud or intentional misrepresentation on the part of the Policyholder or Member.

6. When we cease to offer or elect not to renew all Individual & Family Plans in this state. The termination will be effective on the date specified in the notice from us. This date shall not be earlier than 180 days from the date of the notice.
7. When we cease to offer or elect not to renew an Individual & Family Plan for all individuals in this state. We will send written notice to all Policyholders covered by the affected Plan at least 90 days prior to discontinuation. In addition, we will offer replacement coverage to all affected Policyholders in one of our ongoing Individual & Family Plans.
8. When we cease to offer or elect not to renew an Individual & Family Plan to individuals in a specified Service Area because of an inability to reach an agreement with the health care providers or organization of health care providers to provide Services under this Contract within that specified Service Area, we will send written notice to all Policyholders covered by this Contract at least 90 days prior to discontinuation. In addition, we will offer to all affected Policyholders all other Individual & Family Plans that we offer in our Service Area, for which the affected Policyholders are eligible.
9. When we are ordered by the Director to discontinue coverage in accordance with procedures specified or approved by the Director upon finding that the continuation of the coverage would not be in the best interests of the Members or impair our ability to meet contractual obligations.
10. In the case of a plan that delivers Covered Services through In-Network Providers, when we no longer have any Members living or residing in our Service Area.

If you enrolled through HealthCare.gov and you wish to terminate your coverage or coverage for a Dependent, termination arrangements must be coordinated through HealthCare.gov. Please contact HealthCare.gov for assistance.

9.4.1 Termination Date

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

1. The date this Contract terminates as specified in this section 9;
2. The last day of the month through which the Premium was paid when the Policyholder requests termination of coverage;
3. For a Policyholder, the last day of the month in which the enrolled Policyholder ceases to reside in our Service Area, as stated in section 13;
4. For the enrolled Spouse of a Policyholder, the last day of the month in which the enrolled Spouse ceases to resides in our Service Area, as stated in section 13;
5. For a Dependent child enrolled on a Child-only Plan, the last day of the month in which the child ceases to resides in our Service Area, as specified in section 13;
6. For a Member, the date of disenrollment from this Contract, as described in section 9.4.2;
7. For a deceased Member, after documentation has been submitted, the date of death; and
8. For a Family Member, the last day of the month in which the individual no longer qualifies as an Eligible Family Dependent.

If you enrolled through HealthCare.gov, termination arrangements must be coordinated through HealthCare.gov and will be subject to HealthCare.gov termination date provisions. Please contact HealthCare.gov for assistance.

The following Members may be eligible to maintain enrollment under a separate policy with no lapse in coverage provided that a completed application and the associated initial Premium payment is received by us no later than 30 days from the last date of coverage under this Contract:

- Enrolled Family Members who no longer meet the definition of an Eligible Family Dependent, as specified in section 12;
- Enrolled Family Members who lose coverage as a result of the death of the Policyholder.

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

9.4.2 Disenrollment from this Individual & Family Plan Contract

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

- You have filed false claims with us;
- You have allowed a non-Member to use your Member ID card to obtain Services; or
- You provided false information on your application for coverage or on any subsequent form requesting a change to your coverage.

9.4.3 Termination and Rescission of Coverage Due to Fraud or Abuse

Coverage under this Contract, 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 Individual & Family Plan.

If coverage is rescinded, Providence Health 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 a 30-day notice before rescinding your coverage.

9.4.4 Non-Liability After Termination

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

9.4.5 Notice of Creditable Coverage

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

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

10. MEMBER RIGHTS AND RESPONSIBILITIES

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

Members have the right to:

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

Members have the responsibility to:

- Read and understand the information in and the terms of your Contract. We will have no liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact us. We will assist you in understanding and complying with the terms of the Plan.
- Talk openly with your physician or provider, understand your health problem and work toward a relationship built on mutual trust and cooperation.
- Develop mutually agreed upon treatment goals with your Qualified Practitioner, to the degree possible, and follow treatment plans and instructions.
- Supply to the extent possible information Providence Health Plan and your physicians or providers need to provide care.
- Do your part to prevent disease and injury. Try to make positive, healthful choices. If you do become ill or injured, seek appropriate medical care promptly.
- Treat your physicians or providers courteously.
- Make your required Copayment at the time of Service.

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

Providence Health Plan has the responsibility to:

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

11. GENERAL PROVISIONS

11.1 AMENDMENT OF PLAN

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

11.2 BINDING EFFECT

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

11.3 CIRCUMSTANCES BEYOND THE CONTROL OF PROVIDENCE HEALTH PLAN

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

11.4 CHOICE OF STATE LAW

The laws of the State of Oregon govern the interpretation of this Contract and the administration of benefits to Members.

11.5 DUPLICATING PROVISIONS

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

11.6 DUTY TO COOPERATE AND TO PROVIDE RELEVANT INFORMATION

The Policyholder and all Members are required to cooperate with us in all manners reasonably related to securing any Member's rights, or our rights, under this Contract, including, but not limited to, providing, upon request, all information relevant to eligibility, to coverage, to coordination of benefits, or to third-party or subrogation matters. Policyholders warrant that all information contained in applications, questionnaires, forms, or statements submitted to us is true, correct, and complete. If any Member fails to provide information required to be provided under this Contract or knowingly provides incorrect or incomplete information, then the rights of that Member, and of any Family Members may be terminated, as described in section 9.4.

11.7 HOLD HARMLESS

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

11.8 INFORMATION AVAILABLE UPON REQUEST

The following information about Providence Health Plan is available upon request from the Oregon Division of Financial Regulation:

- Company financial information.
- Annual summary of Grievances and Appeals.
- Annual summary of utilization review policies.
- Annual summary of quality assessment activities.
- Annual summary of network monitoring to ensure that all Covered Services are reasonably accessible to Members.
- A summary of the results of all federal reports and accreditation surveys available to the public.
- A summary of health promotion and disease prevention activities.

This information is available by calling 503-947-7984 or by writing to:

Oregon Division of Financial Regulation,
Consumer Protection Unit,
350 Winter Street NE, Room 440-2,
Salem, OR 97301-3883

You also can contact them through their website at https://dfr.oregon.gov.

11.9 INTEGRATION

This Contract, consisting of this document, the Benefit Summary and any Supplemental Benefit Summary, and any Endorsement or amendments to those documents, embodies the entire Contract of the parties. There are no promises, terms, conditions or obligations other than those contained herein. This Contract shall supersede all other communications, representations or agreements, either verbal or written, between the parties.

11.10 LEGAL ACTION

No legal proceeding may be brought to recover benefits from this Contract until receipt of a final decision from the Providence Health Plan Grievance Committee. After such a decision, an Appeal may lie with an Independent Review Organization (IRO). In the event a right to IRO review exists and you elect to seek such review, it will be binding and final, both on you and on Providence Health Plan. All other challenges to the final decision of the Grievance Committee must be brought in Oregon state court, either in your county of residence or such other county as mutually agreed upon between you and the Plan. In the alternative, you may

request that the Plan agree to submit the dispute to binding arbitration before a single arbitrator under the rules of the United States Arbitration & Mediation Service in your county of residence or such other county as mutually agreed upon between you and the Plan. Any such arbitration shall be under Oregon law, in accordance with USA&M's Rules for Arbitration, and the arbitrator's decision shall be final and legally binding and judgment may be entered thereon. No such action may be brought later than three years after the Grievance Committee's decision was issued. Irrespective of whether the Grievance is appealed to a court or an arbitrator, neither party shall, under any circumstance, be liable to the other for any special, incidental or consequential damages, or for any tort liability (including any punitive or exemplary damages), in any way related to this Contract.

11.11 MEMBER RESPONSIBILITY

It is your responsibility to read and to understand the terms of this Contract. We will have no liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Contract. If you have any questions or are unclear about any provision concerning this Contract, please contact us. We will assist you in understanding and complying with the terms of this Contract.

11.12 MEMBER ID CARD

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

11.13 NON-TRANSFERABILITY OF BENEFITS

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

11.14 NON-WAIVER

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

11.15 NO RECOURSE FOR ACTS OF PROVIDERS

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

11.16 NO REINSTATEMENT BY ACCEPTANCE OF PAYMENT

If this Contract is terminated for any reason, our acceptance of Premium after notice of the termination shall not guarantee a reinstatement of this Contract. Any reinstatement must be agreed to by both us and the Policyholder. We shall refund any payment we accepted, less any outstanding balance, to the Policyholder upon discovery that the payment was accepted without mutual agreement to reinstate.

11.17 NOTICE

Any notice required of us under this Contract shall be deemed to be sufficient if mailed to the Policyholder by postal or electronic means at the address appearing on the records of Providence Health Plan. Policyholders enrolled through Providence Health Plan are responsible for notifying Providence Health Plan as soon as possible of any change in address. Policyholders enrolled through HealthCare.gov are responsible for notifying HealthCare.gov as soon as possible of any change in address. Policyholders who move should call Customer Service as soon as possible and provide the new address. Notices of termination of health insurance coverage will not be sent by electronic means. Any notice required of you by Providence Health Plan shall be deemed sufficient if received via the contact link provided on our website at ProvidenceHealthPlan.com or mailed by postal or electronic means to the principal office:

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

11.18 PHYSICAL EXAMINATION AND AUTOPSY

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

11.19 PREMIUM REBATES

If applicable, we will issue premium rebates in accordance with federal Medical Loss Ratio requirements directly to the Policyholder for any Members covered under this Individual & Family Plan.

11.20 PROFESSIONAL REVIEW AND RIGHT TO EXAMINE RECORDS

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

All Members, for purposes other than utilization review, quality assurance and peer review, may be required to authorize any provider to give and discuss with us any information relating to any condition for which benefits are claimed under this Contract. We may transfer this information between providers or other organizations who are treating you or performing a Service on our behalf.

If you do not consent to the release of records or to discussions with providers, we will be unable to determine the proper payment of any benefits and will deny the claims accordingly. Consent to the release of records and discussion with providers is a condition of payment of any benefits. Neither the consent to, nor the actual examination of the records or discussion with providers will constitute a guarantee of payment.

11.21 PRORATION OF BENEFITS

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

11.22 PROVIDER PAYMENTS

Providence Health Plan pays In-Network Providers on a discounted fee-for-service arrangement. Hospitals are reimbursed based on the Services they provide. The Hospitals are motivated to provide the right amount of care in the proper setting for their patients. Hospitals work with Primary Care Providers and other providers to give Members quality care and to keep health care costs within budget.

If you would like to receive additional detailed information regarding the reimbursement arrangements Providence Health Plan holds with our In-Network Providers, please call Customer Service.

11.23 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.

11.24 SUGGESTIONS

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

11.25 WORKERS' COMPENSATION INSURANCE

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

12. DEFINITIONS

The following are definitions of important terms used in this Individual & Family Plan Contract and appear throughout as Capitalized text.

Adverse Benefit Determination
See section 7.

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

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

Annual
Annual means once per Calendar Year.

Appeal
See section 7.

Approval Notice
Approval Notice means the electronic or written communication sent by Providence Health Plan indicating that you and/or your Eligible Family Dependent(s) have been approved for coverage under this Contract.

Note: The Approval Notice is not a guarantee of coverage under this Contract. In order for coverage to become effective, you must remit the initial premium within the time period specified in the Approval Notice.

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

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

Authorized Representative
See section 7.

Benefit Summary
Benefit Summary means the document with that title which is part of this Individual & Family Plan Contract and which summarizes the benefit provisions under this Contract.

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

Child-only Plan
Child-only Plan means a Contract covering only a Dependent child under 21 years of age (age 0-20 years).

Cochlear Implant
See section 4.12.11.

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

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

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

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

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

Covered Service
Covered Service means a Service that is:

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

Custodial Care
Custodial Care means Services that:

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

Such Services will still be considered Custodial Care even if:

- You are under the care of a physician;

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

<u>Deductible</u>
See section 3.12.1.

<u>Domestic Partner</u>
A Domestic Partner is:
- At least 18 years of age; and
- Has entered into a domestic partnership with a member of the same sex; and
- Has legally registered a Declaration of Domestic Partnership and obtained a Certificate of Registered Domestic Partnership in accordance with Oregon state law.

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

<u>Durable Medical Equipment (DME)</u>
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.

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

<u>Effective Date of Coverage</u>
Effective Date of Coverage means the date upon which coverage under this Contract commences for a Member.

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

Placement for adoption or foster care means the assumption and retention by a Policyholder or Spouse or Domestic Partner, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child or placement for foster care (an individual who has

not attained 18 years of age as of the date of the adoption or placement for adoption or foster care). The child's placement with a Policyholder or Policyholder's legally recognized Spouse terminates upon any termination of such legal obligations.

The limiting age for each Dependent child who is enrolled as an Eligible Family Dependent is age 26 and such Members shall become ineligible for coverage under this Contract on the last day of the month in which their 26th birthday occurs, except:

- When an Eligible Family Dependent is enrolled on a Child-only Plan, the limiting age is 20, and such a Member shall become ineligible for coverage under this Contract on the last day of the month in which their 21st birthday occurs.

Enrolled Eligible Family Dependents who become ineligible for coverage under this Contract may be eligible to continue coverage under a separate Contract as specified in section 9.4.

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

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

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

Emergency Medical Condition
See section 4.5.1.

Emergency Medical Screening Exams
See section 4.5.1.

Emergency Services
See section 4.5.1.

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, 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.

Experimental/Investigational
Experimental/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 Experimental/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 experimental/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 Experimental/Investigational and will make this available for review upon request.

Family Member
Family Member means an Eligible Family Dependent who is properly enrolled in and entitled to Services under this Contract. A Child-only Family Member means an Eligible Family Dependent, of a non-enrolled Policyholder.

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

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

Global Fee
See section 4.13.2.

Grievance
See section 7.

HealthCare.gov
HealthCare.gov means the Health Insurance Marketplace for purchasing health insurance as required by the Affordable Care Act.

Hearing Aid
See section 4.12.11.

Hearing Assistance Technology
See section 4.12.11.

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

Hospital
Hospital means an institution which:
1. Maintains permanent full-time facilities for bed care of resident patients;
2. Has a physician or surgeon in regular attendance;
3. Provides continuous 24-hour-a-day nursing Services;
4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
5. Is legally operated in the jurisdiction where located; and
6. Has surgical facilities on its premises or has a contractual agreement for surgical Services with an institution having a valid license to provide such surgical Services.

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

Individual Application
Individual Application means the electronic or paper document created by us that must be completed by an individual seeking coverage under this Individual & Family Plan Contract.

Individual & Family Plan Contract
Individual & Family Plan Contract, also referred to as Contract, means the provisions of this Individual & Family Plan document, the Benefit Summary, any endorsements or amendments to those documents, and those policies maintained by Providence Health Plan which clarify any of those documents.

In-Network
In-Network covered services are found in the Benefit Summary. The summary explains Covered Services performed by a Medical Home. Details about Services received through a Medical Home Referral to an In-Network Provider are also explained.

In-Network Dentist
In-Network Dentist shall mean those independent licensed dentists and licensed expanded practice dental hygienists who have contracted with the Plan to provide dental Services at negotiated fees for Members of the Plan. In-Network Dentists are not employers of nor supervised by the Plan.

In-Network Provider
In-Network Provider means an Outpatient Surgical Facility, Home Health Provider, Hospital, Qualified Practitioner, Qualified Treatment Facility or Skilled Nursing Facility that has a written agreement with Providence Health Plan to participate as a health care provider for this Plan. For Native American Indian and Alaskan Native Members, Covered Services

obtained through Indian Health Services are considered to be Covered Services obtained from an In-Network Provider.

<u>Independent Freestanding Emergency Department</u>

Independent Freestanding Emergency Department means a health care facility that:

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

<u>Medical Home</u>

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

<u>Medical Home Referral</u>

Medical Home Referral is a request through your Medical Home provider for Services. These Services must be medically necessary. Services must be for an In-Network Provider outside of your medical home. Members may need Prior Authorization.

<u>Medically Necessary</u>

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:

a. 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:
    1. 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;
    2. Clinically appropriate, in terms of type, frequency, extent, site and duration; and considered effective for the Member's medical condition;
    3. Not primarily for the convenience of the Member or Qualified Practitioner; and
    4. Not more costly than an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis, prevention or treatment of that Member's illness, injury or disease.

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

Member
Member means a Policyholder or Eligible Family Dependent who is properly enrolled in and entitled to Services under this Contract.

Mental Health
Mental Health means any mental disorder covered by diagnostic categories listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), such as, but not limited to, major depressive disorder, autism spectrum disorder, dissociative identity disorder, gender dysphoria, and Substance Use Disorder.

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

Out-of-Pocket Maximum
See section 3.12.2.

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

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

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

Plan Year
Plan Year means the 12-month period for which Premium rates for this Contract have been approved by the Director. The Plan Year begins on January 1.

Policyholder
Policyholder means the person to whom this Contract has been issued. A policyholder shall be age 18 or older. If enrollment under this Contract consists solely of children under the

age of 21, the adult person who applied for such coverage shall be deemed to be the Policyholder.

Premium

Premium means the monthly rates set by us and approved by the Oregon Division of Financial Regulation as consideration for benefits offered under this Contract. Premium rates are subject to change at the beginning of each Plan Year.

Primary Care Provider

Primary Care Provider means a Qualified Practitioner specializing in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; a certified nurse midwife; or a physician assistant, when providing services under the supervision of a physician; who agrees to be responsible for the Member's continuing medical care by serving as case manager. Members may choose a Qualified Practitioner specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider.

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

Prior Authorization

Prior Authorization or Prior Authorized means a request to us by you or by a Qualified Practitioner regarding a proposed Service, for which our prior approval is required. Prior Authorization review will determine if the proposed Service is eligible as a Covered Service or if an individual is a Member at the time of the proposed Service. To facilitate our review of the Prior Authorization request, we may require additional information about the Member's condition and/or the Service requested. We may also require that a Member receive further evaluation from a Qualified Practitioner of our choosing. Prior Authorization is subject to the terms and provisions of this Contract. More information about Prior Authorizations is stated in section 3.6.

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

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

Providence Connect Network

Providence Connect Network means the special network of Medical Homes and In-Network Providers that have agreed to provide Covered Services for Members of this Plan.

Providence ExpressCare Virtual Visits

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

Providence Health Plan
Providence Health Plan means the nonprofit corporation authorized as a health care service contractor in the state of Oregon that issues this Individual & Family Plan Contract to the Policyholder.

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

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

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

Service Area
See section 13.

Skilled Nursing Facility
Skilled Nursing Facility means a convalescent or chronic disease facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or certified as a "Skilled Nursing Facility" by the Secretary of Health and Human Services pursuant to Title XVIII of the Social Security Act as amended.

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

Substance Use Disorder
Substance Use Disorder means an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological or physical adjustment to common

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

Urgent Care

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

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

Usual, Customary and Reasonable (UCR)

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

When a Service is provided by an Out-of-Network Provider, UCR charges will be determined, in Providence Health Plan's reasonable discretion, based on the lesser of:

1. The fee a professional provider usually charges for a given Service;
2. A fee which falls within the range of usual charges for a given Service billed by most professional providers in the same locality or region who have similar training and experience;
3. A fee which is based upon a percentage of the Medicare allowable amount;
4. A fee which is prevalent or which would not be considered excessive in a particular case because of unusual circumstances; or
5. The fee determined by comparing charges for similar Services to a regional or national database adjusted to the geographical area where the Service was performed.

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

Women's Health Care Provider

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

13. SERVICE AREA

Service Area means the geographic area in Oregon within which the Policyholder, the Spouse, or the Child-only Member must physically reside in order to be eligible for coverage under this Contract.

Medical Homes and In-Network Providers are located within the Providence Connect Service Area.

Service Areas include:

All ZIP codes in the following Oregon counties:

Clackamas
Hood River
Multnomah
Washington

Selected ZIP codes in the following Oregon counties:

Yamhill – 97123, 97132

14. NON-DISCRIMINATION AND LANGUAGE ACCESS

14.1 NON-DISCRIMINATION STATEMENT

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, 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.*

14.2 LANGUAGE ACCESS INFORMATION

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: (TTY: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

توجه: اگر به‌زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما .بگیرید تماس
با .باشد می ف (TTY: 711) 1-800-878-4445

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)

Providence
Health Plan

Our Mission

As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Our Values

Compassion | Dignity | Justice | Excellence | Integrity

Questions? We're here to help.

Speak to one of our Customer Service representatives at 503-574-7500 or 800-878-4445 (TTY: 771), 8 a.m. to 5 p.m. (Pacific Time) Monday through Friday.
ProvidenceHealthPlan.com

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