



2024 Summary Plan Description



**SAIF Corporation
Health Benefits Plan**



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1. INTRODUCTION

Statement from Plan Sponsor

SAIF Corporation has designed this Plan in cooperation with Providence Health Plan. The benefits under the Plan are provided by SAIF Corporation on a self-insured basis. SAIF Corporation has contracted with Providence Health Plan to process claims and provide customer service to Plan Members. However, Providence Health Plan does not insure or otherwise guarantee any benefits under the Plan.

SAIF Corporation Human Resources: 503-373-8040

SAIF Health Plan Online: <https://healthplans.providence.org/members/member-groups/saif/>

Customer Service Quick Reference Guide:

Medical, Mental Health, Substance Use Disorder and prescription drug claims and benefits, and General assistance with your Plan

503-574-7500 (local / Portland area)
800-878-4445 (toll-free)
711 (TTY)
ProvidenceHealthPlan.com

Mail order prescription drug services

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)

Unified Life

800-342-2641 (toll-free)

LifeBalance

503-234-1375 (local / Portland area)
888-754-LIFE (toll-free)

Provider Directory

ProvidenceHealthPlan.com/findaprovider

1.1 KEY FEATURES OF YOUR SAIF CORPORATION HEALTH BENEFITS PLAN

- Some capitalized terms have special meanings. Please see section 16, Definitions.
- In this Summary Plan Description, Providence Health Plan and this SAIF Corporation Health Benefits Plan are referred to as “we,” “us” or “our.” Members enrolled under this Plan are referred to as “you” or “your.”
- Coverage under this Plan is provided through:
 - Our Providence Signature Network of In-Network Providers located in our service area;
 - Our national network of In-Network Providers; and
 - Out-of-Network Providers.
- With this Plan, Members will generally have lower out-of-pocket expenses when obtaining Covered Services from In-Network Providers. Members may, however, obtain most Covered Services from Out-of-Network Providers, but that option will result in higher out-of-pocket expenses. Please see section 4 and your Plan Benefit Summary for additional information.
- The following Covered Services must be obtained from In-Network Providers:
 - Telehealth Services, see section 5.1.2.
 - E-mail Visit Services, see section 5.1.3.
 - Prescription drugs, see section 5.9.
 - Temporomandibular joint (TMJ) Services, see section 6.2.1.
 - Human Organ/Tissue Transplant Services, see section 6.1.
 - Tobacco Use Cessation Services, see section 5.2.8.
 - Water births, as specified in section 5.3.4;
 - Bariatric Surgery Services, see section 6.4
 - Any item listed in your Benefit Summary as “Not Covered” under Out-of-Network.
- All Members are encouraged to choose a 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 In-Network Providers 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.
- **Certain Covered Services require an approved Prior Authorization, as specified in section 4.4.**
- Coverage under this Plan is available 24 hours a day, seven days a week and during periods of domestic or foreign travel.
- All Covered Services are subject to the provisions, limitations and exclusions that are specified in this Plan. You should read the provisions, limitation and exclusions before seeking Covered Services, because not all health care services are covered by this Plan.
- This Plan consists of this Summary Plan Description plus the Benefit Summary(ies), any Endorsements and amendments that accompany these documents, and those policies maintained by Providence Health Plan which clarify any of these documents. In the event of any conflict between these documents, they are to be interpreted in the following order of priority: (1) Endorsements and amendments, (2) Summary Plan Description, (3) Benefit Summary(ies), and (4) applicable Providence Health Plan policies.

2. WELCOME TO PROVIDENCE HEALTH PLAN

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

2.1 SAIF CORPORATION HEALTH BENEFITS PLAN

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

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

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

Whenever you visit a Provider:

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

2.2 SUMMARY PLAN DESCRIPTION

This Summary Plan Description contains important information about the health plan coverage offered to employees of SAIF Corporation. It is important to read this Summary Plan Description carefully as it explains your Plan benefits and Member responsibilities. If you do not understand a term that is used, you may find it in Definitions, section 16. If you need additional help understanding anything in this Summary Plan Description, 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 Summary Plan Description is not complete without your:

- **SAIF Corporation Medical Benefit Summary** and any other Benefit Summary documents, such as prescription drug, men's voluntary sterilization, and hearing aid. While these benefit summary documents are included in this Summary Plan Description, they are also available when you register for a myProvidence account as explained in section 2.4 or through the SAIF Corporation micro-site at <https://healthplans.providence.org/saif/pages/default.aspx>. Benefit Summaries detail your Deductibles, Copayments and Coinsurance for Covered Services and also provide other important information.
- **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 your Employer or Customer Service.

2.3 CUSTOMER SERVICE

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

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

Contacting Providence Customer Service

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

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

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

2.4 REGISTERING FOR A MYPROVIDENCE ACCOUNT

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

2.5 YOUR MEMBER ID CARD

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

- Your Member number and group number
- Important phone numbers

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

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:

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

2.6 PROVIDENCE NURSE ADVICE LINE

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

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

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

Please have your Member ID Card available when you call.

2.7 WELLNESS BENEFITS

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

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

- 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 ProvidenceHealthPlan.com.
- LifeBalance Program
 - Discounts on health, wellness, recreational and cultural activities.
 - You can access your LifeBalance program by calling 503-234-1375 or 888-754-LIFE or visiting www.LifeBalanceProgram.com.
- Travel Assistance Services
 - Emergency logistical support to Members traveling internationally or people traveling 100 miles from home.
 - Contact by calling 609-986-1234 or 800-872-1414 or visit www.assistamerica.com.
- Identity Theft Protection
 - Identity theft protection program for Providence Health Plan Members.
 - Please call 614-823-5227 or 877-409-9597 or visit www.assistamerica.com/Identity-Protection/Login to sign up for the program; you will need your Health Plan Member ID number, and tell them your code is 01-AA-PRV-01193.

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), which we obtain so we can provide you with the benefits and coverage under your Employer's plan. Providence Health Plan maintains policies that protect the confidentiality of personal information, including Social Security numbers, obtained from its Members in the course of its regular business functions.

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

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

Appointment of Authorized Representative

You are entitled to appoint an individual to act as your authorized representative to pursue any claim you have for benefits. To ensure privacy and to address other issues, Providence's policy on Appointment of Authorized Member Representatives, and the form for doing so,

may be accessed through our website at ProvidenceHealthPlan.com/forms. The policy does not apply to an attorney at law retained by you directly to represent your interests with respect to your benefits, but does apply to attorneys who represent a medical service provider whose services are a part of the claim in issue.

Confidentiality and your Employer

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

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

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

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

3. ELIGIBILITY AND ENROLLMENT

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

3.1 ELIGIBILITY

3.1.1 Eligible Employees

All regular full-time and part-time employees who regularly work a minimum average of 20 or more hours per week may enroll themselves and eligible dependents in SAIF's health benefits plan on the date of hire. Regular full- and part-time employees who work less than an average of 20 hours per week are not eligible to enroll in SAIF's health benefits plan.

Active Working Retirees with Oregon Public Employee Retirement System (PERS) benefits who are rehired for temporary employment lasting at least 90 days, working at least 20 hours per week, and are not enrolled in a SAIF Retiree medical plan, may enroll in a SAIF medical plan under the same terms as active employment. Active Working Retirees will no longer be eligible if the temporary employment ends or if they work less than 20 hours per week.

3.1.2 Eligible Family Dependents

Eligible Family Dependents are:

- A legally married spouse, registered domestic partner, or un-registered domestic partner. Unregistered domestic partners must meet the definition of a domestic partner based on criteria established by Providence Health Plan.
- Dependent children to age 26 who are natural children, step-children, children of a domestic partner. Children under legal guardianship to age 18. A child paced for or pending adoption, and a legally adopted child.
- Dependent children who are incapable of self-sustaining employment because of a physical or mental handicap. Such children may be eligible to remain covered even though they are over 26. To be eligible, the handicap must have occurred before the child's 26th birthday (additional affidavit will be required).
- A Child by Affidavit includes but not limited to a foster child, grandchild, child placed for adoption, or court ordered placement of a child who lives in the household of the eligible employee, and is the eligible employee's IRS dependent. The employee must provide court ordered documentation of guardianship and the notarized Affidavit of Child Dependency upon enrollment. Coverage ends the last day of the month in which the court ordered guardianship ends or age 26. An eligible employee may not add a child by affidavit age 26 or older to coverage unless they can provide court ordered documentation for responsibility of the child beyond the age of 26.
- The biological child of an eligible dependent child of an eligible employee, spouse, or domestic partner (a grandchild by affidavit) and meets all the following criteria:
 - The child's parent will not be older than age 26 on the last day of the plan year, is unmarried and without a domestic partner. Both the child's parent and the child live in the household of the eligible employee, and both the child and grandchild are the eligible employee's IRS dependent. The child's parent has health coverage through the eligible employee. The grandchild is automatically covered as an eligible dependent for the first 31 days from birth

without documentation and Affidavit in place. The Affidavit and any appropriate documentation must be on file the first of the month following the event date in order to meet eligibility requirements and continue coverage under the Plan rules. An eligible employee may not add a grandchild age 26 or older to their coverage unless they can provide court ordered documentation for responsibility of the child beyond the age of 26.

3.1.3 SAIF Retirees

Employees who are not eligible for Medicare, retire from SAIF Corporation, and apply for Oregon Public Employee Retirement System (PERS) benefits within 60 days from the date of separation may continue enrollment in SAIF Retiree medical plan benefits for themselves and their eligible dependents. The retiree must pay the full cost of the premiums.

3.1.4 SAIF Retiree's Spouse or Domestic Partner

Coverage may be continued for the spouse or domestic partner of a SAIF retiree until that person becomes eligible for Medicare. A retiree's non-Medicare eligible spouse or domestic partner, who is enrolled at the time of the SAIF retiree's retirement or within 60 days thereafter, will be allowed to continue to self-pay for health benefits coverage if the retiree loses eligibility.

3.1.5 SAIF Retiree's Eligible Dependent Children

Eligible dependent children to age 26 of the retiree who are enrolled at the time of the retiree's retirement will be allowed to continue to self-pay for health benefits coverage if the retiree loses eligibility. Dependents losing eligibility will be offered an opportunity to continue coverage under the conditions stated in Section 11, Continuation of Group Medical Benefits.

3.1.6 SAIF Active Working Retiree Temporary Employment

Active Working Retirees are defined as those who are rehired for temporary employment lasting at least 90 days and working at least 20 hours per week. Active Working Retirees will be eligible for premium contributions by SAIF Corporation. When either temporary employment ends or the Active Working Retiree works less than 20 hours per week, SAIF Corporation will no longer make premium contributions.

Coverage will end if the Active Working Retiree did not initially enroll in a SAIF Retiree medical plan.

Short Term Active Working Retirees are defined as those who are rehired for temporary employment lasting less than 90 days. Short Term Active Working Retirees are not eligible for benefits.

3.1.7 Ineligible Individuals – Temporary Employees

Long-term and short-term temporary employees, student works, college interns, agency temporary employees, and short term active working retirees are not eligible for the Providence Health Plan. This section does not apply to Active Working Retirees working more than 20 hours per week on assignments lasting more than 90 days.

3.2 EMPLOYEE ELIGIBILITY AND ENROLLMENT

3.2.1 Employee Effective Date

Coverage begins for an Eligible Employee on the date of hire or on the first day after other coverage has ended.

3.2.2 Employee Enrollment

The Eligible Employee must enroll through SAIF's HR Self Service system. To obtain coverage, an Eligible Employee must enroll within 31 days after becoming eligible.

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

In certain situations, you and/or your Eligible Family Dependents may qualify to enroll during a special enrollment period. See section 3.4 for additional information.

An Eligible Employee who enrolls on the Plan is referred to as a Subscriber (see Definitions section 16).

3.2.3 Declining Enrollment

The Eligible Employees declining enrollment must complete the Declination of Coverage process by contacting SAIF's Human Resources Division.

3.3 DEPENDENT ELIGIBILITY AND ENROLLMENT

3.3.1 Eligibility Date for Eligible Family Dependents

Coverage begins for each Eligible Family Dependent depending on the qualifying event that applies:

1. The Effective Date of Coverage for the Subscriber if the individual enrolls their Eligible Family Dependent on that date;
2. The first of the month following the date of the Subscriber's marriage, for any Eligible Family Dependents (Spouse or child) acquired on that date;
3. The date of birth of the biological child of the Subscriber or Spouse;
4. The date of birth of the biological child of an enrolled dependent child of the Subscriber or Spouse;
5. The date a child is placed with the Subscriber or the Spouse for the purpose of adoption or foster care by the Subscriber or the Spouse;
6. The date the Subscriber or the Spouse is required to provide health coverage to a child under a qualified medical child support court or administrative order; or
7. The date legal guardianship status of a child begins for the Subscriber or Spouse.

3.3.2 Additional Requirements for Eligible Family Dependent Coverage

An Eligible Employee may cover her or his Eligible Family Dependents ONLY if she or he is also covered, and SAIF Corporation receives her or his completed enrollment requesting Dependent coverage.

3.3.3 Eligible Family Dependent Enrollment

You must enroll Eligible Family Dependents through SAIF's HR Self Services system and be accepted by SAIF Corporation. No Eligible Family Dependent will become a Member until SAIF Corporation approves that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within 31 days after becoming eligible (see section 3.3.4 regarding newborn, newly adopted children, and newly fostered children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period or if she or he experiences an eligible status change. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 3.4.

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

A newborn, newly adopted child, or newly fostered child of a Member who meets the definition of an Eligible Family Dependent is covered from the date of birth or placement for the purpose of adoption or foster care as long as enrollment occurs within 60 days of the birth date or placement for adoption or foster care and additional Premium, if any, is paid to SAIF Corporation. If the enrollment and payment of additional Premium, if any, are not accomplished within this time period, no services will be covered for the child. Enrollment after this time period may be accomplished as outlined in sections 3.3.6 and 3.4.

3.3.5 Children of Legal Guardianship

A child for whom you, your Spouse, or your Domestic Partner has legal guardianship is eligible to enroll as an Eligible Family Dependent as specified in sections 3.1.2 and 3.3.1. Coverage for a child of legal guardianship will terminate the end of the month in which the child attains age 18 (the end of the month of the child's 18th birthday.) Children for whom legal guardianship extends beyond age 18 are eligible to continue enrollment so long as the child qualifies as an incapacitated adult dependent.

3.3.6 Open Enrollment Period

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

3.3.7 Changes in Eligibility

When an eligibility change occurs, SAIF Corporation Human Resources must be notified of the change within 60 days of the qualifying event. Address changes can be made over the phone by calling Providence Customer Service or by visiting the Providence website.

If you are an active employee, you, must submit the following changes through SAIF's HR Self Services system. Contact SAIF Human Resources if you do not have electronic access to SAIF's HR system. You need to submit the electronic changes to SAIF Corporation for you and all your Eligible Family Dependents when:

- You have an address change;
- You marry and wish to enroll your new Spouse;
- If you have a new registered domestic partner or un-registered domestic partner;
- A Dependent's limiting age occurs; or
- You or one of your Dependents has a legal name change.

If a Subscriber or Eligible Family Dependent, as specified in section 3.1.2, enters full-time military, naval or air service, the Plan will continue to provide benefits to the Subscriber or Eligible Family Dependent as described in section 14.25.

If you have questions regarding eligibility changes, please contact SAIF Corporation's Human Resources Division.

3.3.8 Members No Longer Eligible for Coverage

If you divorce or are legally separated, your Spouse or Domestic Partner is no longer eligible for coverage as a Dependent, you must dis-enroll your Spouse or Domestic Partner as a Dependent from your Plan at the time the divorce or legal separation is final. Your Spouse's or Domestic Partner's children will be able to continue coverage under the Plan so long as the children continue to qualify as your Eligible Family Dependent(s) (see Section 3.1.1-3.1.5).

You must inform SAIF Corporation of these changes through SAIF's HR Self Service system. Contact SAIF Human Resources if you do not have electronic access to SAIF's HR system. Check with SAIF Corporation's Human Resources Division to determine the effective date of any enrollment or disenrollment.

Those who no longer qualify as your Eligible Family Dependents may be eligible to continue coverage as described under sections 11 and 12. Ask SAIF Corporation's Human Resources Division for continuation coverage eligibility information.

3.4 SPECIAL ENROLLMENT PERIODS

If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your Spouse) during a previous Open Enrollment Period (as stated in section 3.3.6), you may be eligible to enroll yourself or the Eligible Family Dependent during a "special enrollment period" provided that you request enrollment within 30 days of the qualifying event and meet the applicable requirements stated in this section.

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

- Enroll in the coverage currently elected by the Subscriber; or
- If SAIF Corporation has elected to provide more than one benefit option, enroll in any benefit option for which the Subscriber and Eligible Family Dependent is eligible.

The following examples show what life events are eligible for a "special enrollment."

3.4.1 Loss of Other Coverage

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

- a) The person was covered under a group health plan or had other health coverage (includes benefits consisting of medical care under any hospital or medical services policy or certificate, or HMO) at the time coverage under this policy was first offered to the person; and
- b) The person stated in writing that coverage under such group health plan or health coverage was the reason for declining enrollment; but only if we required such a statement and provided the person with notice of such requirement (and the consequences of such requirement) at such time; and
- c) Such coverage:
 - was under a COBRA Continuation provision and the coverage under such a provision was exhausted, except when the person failed to pay timely premium, or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact); or
 - was not under a COBRA Continuation provision and the coverage was terminated as a result of:
 1. The individual’s loss of eligibility for the coverage; including as a result of legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment; except when the person failed to pay timely premium or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact); or
 2. The individual’s loss of eligibility for coverage under the Children’s Health Insurance Program (CHIP), Medicaid, Medicare, TRICARE, Indian Health Service or domestic or foreign publicly sponsored or subsidized health plan; including but not limited to the Oregon Health Plan (OHP); and the individual applies for coverage under this Plan within 63 days of the termination of such coverage; or
 3. The termination of contributions toward such coverage by the current or former employer; or
 4. The individual incurring a claim that exceeds the lifetime limit on all benefits; and the individual applies for coverage under this Plan within 30 days after the claim is denied.

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

3.4.2 New Eligible Dependents

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

The “special enrollment period” shall be a period of 30 days and begins on the later of:

- the date Dependent coverage is made available under this Plan; or
- the date of the marriage, birth, or adoption or placement for adoption or foster care.

Effective Date:

in the case of marriage, on the first day of the calendar month following our receipt of the enrollment request, or on an earlier date as agreed to by us; or

- in the case of a Dependent’s birth, on the date of such birth; or
- in the case of a Dependent’s adoption or placement for adoption, the date of such adoption or placement for adoption; or
- in the case of legal guardianship of a Dependent, the date such legal guardianship status begins.

3.4.3 Court Orders

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

Effective Date: The date specified in the court order.

3.4.4 Premium Assistance

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

3.4.5 Change to Full Time Employment Status

A change to your Full Time Employment (FTE) status is considered a qualifying event for purposes of making benefit changes. If your FTE is reduced, and it results in an increase in cost to you, you may cancel benefit coverage for yourself and/or your enrolled dependent(s). If your FTE increases and you are not enrolled in the Plan, you may elect coverage and/or add eligible dependent(s) to your plans. If you are already enrolled in the Plan and your FTE increases, you will not be permitted to change plans.

3.5 SAIF EARLY RETIREE PLAN ELIGIBILITY AND ENROLLMENT

3.5.1 SAIF Early Retiree Plan Eligibility

A non-Medicare Eligible Employee who has retired under PERS and as defined under section 3.1.3 is eligible for coverage under the Providence Early Retiree plan as specified in the Eligible Employee definition. An Eligible Retiree may also elect to enroll Eligible Family Dependents.

3.5.2 Early Retiree Plan Effective Date

Coverage begins under the Early Retiree Benefits first of the month following election and enrollment.

3.5.3 Early Retiree Plan Termination of Coverage

Coverage under Early Retiree Benefits will terminate whenever any Member covered under Early Retiree Benefits becomes eligible for Medicare. Any Dependents who lose coverage as a result of termination of the Subscriber have the right to continue coverage as specified in section 11.

3.5.4 Early Retiree Plan Benefits

Coverage under Early Retiree Benefits may be different than Active Employee Benefits. See your Early Retiree Plan Benefit Summaries and this Summary Plan Description for additional information.

3.6 LEAVE OF ABSENCE AND LAYOFFS

If a Subscriber is granted an approved leave of absence (other than FMLA and OFLA), the Subscriber and their covered dependents may be eligible to continue coverage while on paid leave. The Subscriber may be responsible for paying all the premiums during a leave of absence if the subscriber is on an approved leave without pay. If the Subscriber is on leave without pay (other than FMLA and OFLA), the Subscriber and their covered dependents will be eligible to continue coverage under the COBRA Continuation of Coverage Provisions under the Plan.

If a Subscriber is laid off, the Subscriber and their covered dependents will be eligible to continue coverage under the COBRA Continuation of Coverage Provisions under the Plan.

An Employee who returns to work as an Eligible Employee after coverage has lapsed must re-enroll for coverage as specified in section 3.2.2.

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

4. HOW TO USE YOUR PLAN

Our goal is to help you maintain your health by promoting wellness and preventive care. We encourage you to work closely with one provider, your Primary Care Provider, who can provide most of your care, suggest specialist care, and arrange for Hospital care or diagnostic testing.

This section describes how to use this Plan and how benefits are applied. The level of benefits for Covered Services is shown in the Benefit Summary and described in sections 5 and 6 of this Plan. This Plan is an Open Option Plan. When you receive care from In-Network Providers, coverage is provided under your In-Network benefit; and when you receive care from Out-of-Network Providers, coverage is provided under your Out-of-Network benefit. Some In-Network and Out-of-Network Services are subject to Prior Authorization. See section 4.4 Covered Services That Require Prior Authorization more information.

4.1 IN-NETWORK PROVIDERS

Providence Health Plan has contractual arrangements with certain physicians/providers, Hospitals and facilities. Our contract agreements with these “In-Network Providers” enable you to receive quality health care for a discounted cost.

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

4.1.1 Nationwide Network of In-Network Providers

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

4.1.2 Choosing an In-Network Provider

To choose an In-Network Provider, or to verify if a provider is an In-Network Provider, please refer to our Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider.

Advantages to Using an In-Network Provider

- Your In-Network Provider will work with Providence Health Plan to arrange for any Prior Authorization requirements that may be necessary for certain Covered Services. For more information on Prior Authorization, see section 4.4.
- In most cases when you use In-Network Providers, higher benefit levels will apply and your out-of-pocket expenses will be reduced.
- You will have a wide variety of high-quality In-Network Providers to help you with your health care needs.

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

4.1.3 Indian Health Services Providers

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

Portland Area Indian Health Service
1414 NW Northrup Street, Suite 800
Portland, OR 97209
Telephone: 503-414-5555

4.2 THE ROLE OF A PRIMARY CARE PROVIDER

To encourage optimum health, Providence Health Plan promotes wellness and preventive care. Providence Health Plan believes wellness and overall health is enhanced by working closely with one physician or provider – your Primary Care Provider. Your Primary Care Provider can provide most of your care and, when necessary, coordinate care with other providers in a convenient and cost-effective manner. We recommend that upon joining Providence Health Plan you and each of your family members choose a Network Primary Care Provider as soon as possible.

Please see your Benefit Summary for coverage of preventive Services from a Primary Care Provider.

4.2.1 Primary Care Providers

A Primary Care Provider is a Qualified Practitioner who specializes in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a physician assistant, when providing services under the supervision of a physician; who agrees to be responsible for the continuing medical care by serving as case manager. Members may also choose and self-refer to a physician 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. Child Members may choose a physician specializing in pediatrics as their Primary Care Provider.

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 Primary Care Providers offer maternity care and minor outpatient surgery as well.

IMPORTANT NOTE: Network Primary Care Providers have a special agreement with Providence Health Plan to serve as a case manager for your care. This means not all of our In-Network Providers with the specialties listed above are Network Primary Care Providers. Please refer to the Provider Directory, available online, for a listing of designated Network Primary Care Providers or call your Customer Service team to request a hard copy.

4.2.2 Established Patients with Primary Care Providers

If you and your family already see a provider, check the Provider Directory to see if your provider is a Network Primary Care Provider for Providence Health Plan. If your provider is

participating with Providence Health Plan, let his or her office know you are now a Providence Health Plan Member.

4.2.3 Selecting a New Primary Care Provider

Providence Health Plan recommends that you choose a Primary Care Provider from our Provider Directory, available online, for each covered family member. Call the provider's office to make sure he or she is accepting new patients. It is a good idea to have your previous physician or provider transfer your medical records to your new Primary Care Provider as soon as possible. The first time you make an appointment with your Primary Care Provider, let him or her know you are now a Providence Health Plan Member. On your first visit, make a list of questions or information you would like to discuss with your new Primary Care Provider, including the following:

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

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

4.2.4 Changing Your Primary Care Providers

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

4.2.5 Office Visits

Primary Care Providers

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

Specialists

Your Primary Care Provider will discuss with you the need for diagnostic tests or other specialist services; and may also recommend you see a specialist for treatment.

You also may decide to see a specialist without consulting your Primary Care Provider. Visit our Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider, or call Customer Service to choose a specialist that is an In-Network Provider with Providence Health Plan.

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

Whenever you visit a specialist:

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

Alternative Care Providers

Your Plan includes coverage for office visits to naturopaths, chiropractors, acupuncturists, and massage therapists, as listed in your Benefit Summary. See section 16 for the definition of Alternative Care Provider. For coverage of chiropractic manipulation, acupuncture, and massage therapy, see sections 5.8.17, 5.8.18 and 5.8.19, and your Benefit Summary.

4.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS

As a Member of this Plan, you may choose to receive Covered Services from Out-of-Network Qualified Practitioners and facilities using your Out-of-Network benefit.

Benefits for Covered Services by an Out-of-Network Provider will be provided as shown in the Benefit Summary. See section 4.4, Prior Authorization requirements.

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

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

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

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

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

After you meet your Deductible, if applicable, and if the Services provided are Medically Necessary Covered Services, the Plan 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 16 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 are only estimates of what may apply):

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

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

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

- Telehealth Services (see section 5.1.2).
- E-mail Visits (see section 5.1.3).
- Prescription Drugs (see section 5.9).
- Human Organ/Tissue Transplants (see section 6.1).
- Temporomandibular Joint (TMJ) Services (see section 6.2.1).
- Tobacco Use Cessation (see section 5.2.8).
- Retail Health Clinic Visits (see section 5.1.7).
- Bariatric Surgery Services (see section 6.4).
- Any item listed in your Benefit Summary as “Not covered” under Out-of-Network.

Payment for Covered Services Provided Before Disposition of Criminal Charges

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

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

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

4.4 COVERED SERVICES THAT REQUIRE PRIOR AUTHORIZATION

Prior Authorization applies to both In-Network and Out-of-Network Services. Not all Services require Prior Authorization (see the list further in this section). While Prior Authorization is a requirement for coverage of certain Services under this Plan, Prior Authorization is not a treatment directive. The actual course of medical treatment that a Member chooses remains strictly a matter between the Member and his/her provider and is separate from the Prior Authorization requirements of this Plan. Prior Authorization is not a guarantee of benefit payment under this Plan and a Prior Authorization determination does not supersede other specific provisions of this Plan regarding coverage, limitations, exclusions and Medically Necessary Services.

Services received from In-Network Providers:

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

Services received from Out-of-Network Providers:

When Services are received from an Out-of-Network Provider, the Member is responsible for obtaining Prior Authorization. See section 4.3. You or the Out-of-Network Provider must contact Providence Health Plan to obtain Prior Authorization for certain Covered Services. See section 4.3 for additional information about Out-of-Network Providers.

Services requiring Prior Authorization:

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

Note: Pediatric services provided by Randall Children's Hospital for SAIF members may be eligible for in-network benefits if authorization is obtained prior to receiving services. Prior authorization will be subject to medical management criteria as established by PHP.

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, Providence Health Plan 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 1-800-638-0449 to obtain Prior Authorization. Please have the following information ready when calling to request a Prior Authorization:
- The Member's name and date of birth.
- The Member's Providence Health Plan Member number and Group number (these are listed on your Member ID card).
- The Provider's name, address and telephone number.
- The name of the Hospital or treatment facility.
- The scheduled date of admission or date Services are to begin.
- The Service(s) to be performed.

Failure to Obtain Prior Authorization:

If you do not obtain Prior Authorization for Services received from an Out-of-Network Provider, as specified in this section, a 50% **penalty**, not to exceed \$2,500 for each Covered Service, will be applied to the claim. Services that would not otherwise be covered under the Plan are not eligible for this penalty provision.

Should we determine that we would have covered the Service had Prior Authorization been obtained, benefits will be applied to the remaining claim balance after the Prior Authorization Penalty is assessed.

The **penalty** does **NOT** apply to the Deductible, if any, or to the Out-of-Pocket Maximum shown in the Benefit Summary. The penalty also does NOT apply to mental health or substance use disorder services.

4.5 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. 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 annual maximum. (Note: Transplant Covered Services include a separate travel expense benefit; see section 6.1).

4.6 MEDICAL COST MANAGEMENT

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

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

In accordance with Providence Health Plan's medical cost management protocols and criteria specified in this paragraph, Providence Health Plan may approve substitutions for Covered Services under this Plan.

A Substituted Service must:

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

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

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

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

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

4.6.1 Coverage of New Technology and New Application of Existing Technology

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

Emerging and innovative technologies are monitored by Providence Health Plan through review of trend reports from technology assessment bodies, government publications, medical journals, and information provided by providers and professional societies. A systematic process for evaluating a new technology or new application of an existing technology is proactively initiated when sufficient scientific information is available.

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

- Technology must improve health outcomes. The beneficial effects must outweigh any harmful effects on health outcomes. It must improve the length of life, ability to function or quality of life.
- Technology must be as beneficial as any established alternative. It should improve the net health outcome as much, or more, than established alternatives.
- Application of technology must be appropriate, in keeping with good medical standards, and useful outside of investigational settings.
- Technology must meet government approval to market by appropriate regulatory agency as applicable.

- Criteria must be supported with information provided by well-conducted investigations published in peer-reviewed journals. The scientific evidence must document conclusions that are based on established medical facts.
- Opinions and evaluations of professional organizations, panels, or technology assessment bodies are evaluated based on the scientific quality of the supporting evidence.

Technology Evaluation Process

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

Expedited Review

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

4.7 MEDICALLY NECESSARY SERVICES

We believe you are entitled to comprehensive medical care within the standards of good medical practice. Providence Health Plan's medical directors and special committees of In-Network Providers determine which Services are Medically Necessary, as described in section 16, Definitions. Services that do not meet Medically Necessary criteria will not be covered.

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

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

4.8 APPROVED CLINICAL TRIALS

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

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

The following costs are excluded:

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

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

4.9 HOW BENEFITS ARE APPLIED

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

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

4.10 DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS

Your Plan has a Deductible and an Out-of-Pocket Maximum, as stated in your Benefit Summary.

Deductible amounts apply to Out-of-Pocket Maximums.

4.10.1 Understanding Deductibles

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

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

Plans Well-aware and Engaged, Well-aware, and Well:

Separate In-Network and Out-of-Network Deductibles: If you are covered under Plans Well-aware and Engaged, Well-aware or Well as an Active Member or Retiree, your Plan has **separate In-Network and Out-of-Network Deductibles**. An Individual and Family Deductible applies to Covered Services received using your In-Network benefit, and a separate Individual and Family Deductible applies to Covered Services received using your Out-of-Network benefit. **These In-Network and Out-of-Network Deductibles accumulate separately and are not combined.**

Early Retiree Plan:

Common Deductibles: If you are covered under the Early Retiree Plan, your Plan has a **Common Medical/Pharmacy Deductible. The Common Medical/Pharmacy Deductible applies to In-Network and Out-of-Network medical benefits.** The Deductible can be met by using In-Network or Out-of-Network benefits, or a combination of both.

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

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

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

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

- Services not covered by this Plan.
- Services in excess of any maximum benefit limit.
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges.
- Any penalties you must pay if you do not follow Providence Health Plan's Prior Authorization requirements.
- Copayments or Coinsurance specified as not applicable toward the Deductible in any Benefit Summary issued with this Plan.

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

4.10.2 Understanding Out-of-Pocket Maximums

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

Plans Well-aware and Engaged, Well-aware, and Well:

Separate In-Network and Out-of-Network Out-of-Pocket Maximums: If you are covered under Plans Well-aware and Engaged, Well-aware or Well as an Active Member or Retiree, your Plan has separate In-Network and Out-of-Network Out-of-Pocket Maximums. Your In-Network Out-of-Pocket maximum can be met by payments you make for Covered Services received using your In-Network benefit, and your Out-of-Network Out-of-Pocket Maximum can be met by payments you make for Covered Services received your Out-of-Network benefit. **These In-Network and Out-of-Network Out-of-Pocket Maximums accumulate separately and are not combined.**

Early Retiree Plan:

Common Out-of-Pocket Maximums: If you are covered under the Early Retiree Plan, your Plan has a Common Out-of-Pocket Maximum. The Common Out-of-Pocket Maximum includes payments you make for Covered Services using In-Network and Out-of-Network benefits.

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

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

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

- Services not covered under this Plan.
- Services not covered because Prior Authorization was not obtained, as required in section 4.4.
- Services in excess of any maximum benefit limit.
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges.
- Deductibles, Copayments or Coinsurance for a Covered Service* if indicated in any Benefit Summary as not applicable to the Out-of-Pocket Maximum.
- Any penalties you must pay if you do not follow the Providence Health Plan's Prior Authorization requirements.

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

4.11 UNDERSTANDING PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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

What is “balance billing” (sometimes called “surprise billing”)?

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

“Out-of-Network” describes providers and facilities that haven't signed a contract with your health plan. Out-of-Network Providers may be permitted to bill you for the difference between

what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than In-Network costs for the same service and might not count toward your annual Out-of-Pocket Maximum.

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

You are protected from balance billing for:

Emergency Services

If you have an emergency medical condition and get Emergency Services from an Out-of-Network Provider or facility, the most the Provider or facility may bill you is your plan’s In-Network cost-sharing amount (such as Deductibles, Copayments and Coinsurance). You cannot be balance billed for these Emergency Services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balance 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. You may also contact the U.S. Department of Health and Human Services and file a complaint by calling 800-985-3059 (toll-free) or going to

<https://www.cms.gov/nosurprises/consumers>.

5. COVERED SERVICES

This section describes Services that, when Medically Necessary and not otherwise excluded or limited, are covered under this Plan. Refer to your Benefit Summary for your Member Copayments/Coinsurance as well as other details of your specific coverage. You can view your Member materials by registering for a myProvidence account on our website at [ProvidenceHealthPlan.com](https://www.providencehealthplan.com) (see section 2.5). If SAIF Corporation modifies your benefits, you will be notified in writing of the changes.

Benefits 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.

See section 6 (the Limitations section) for the specific coverage provisions that apply to the following:

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

5.1 PROVIDER SERVICES

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

Office visits, inpatient and outpatient Hospital visits and home visits with a Qualified Practitioner are covered as shown in your Benefit Summary. Copayments and Coinsurance, as shown in your Benefit Summary, apply to all provider visits except those that: (a) are part of a course of maternity care; (b) are for conditions for which this Plan contains a separate and specific Copayment or Coinsurance amount; or (c) are ancillary to the visit and are billed by the Qualified Practitioner. 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. Missed appointment charges are not covered expenses under this Plan.

5.1.2 Telehealth Services

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

5.1.2.1 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.

5.1.2.2 Office Visits Virtually

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

5.1.2.3 Telemedicine Services

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

- Is Medically Necessary;
- Does not duplicate or supplant a Service that is available to the patient in person;
- Is provided by a Qualified Practitioner;
- Originates at a qualified site, such as a Hospital, rural health clinic, federally qualified health center, physician's office, community mental health center, skilled nursing facility, renal dialysis center, or public health services center;
- Is delivered through a two-way ~~vide~~ communication that allows the Qualified Practitioner to interact with the Member receiving the Service who is at an originating site.

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

5.1.3 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 (MD), Doctors of Osteopathy (DO), Nurse Practitioners (NP) and Physician Assistants (PA) are the only categories of providers who may be approved for E-mail Visits. In-Network Providers who are authorized to provide E-mail Visits have agreed to use Internet security technology approved by us to protect your information from unauthorized access or release.

To be eligible for the E-mail Visit benefit, you must have had at least one prior office visit with your In-Network Provider within the last 12 months.

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

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

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

- Renewing prescriptions;
- Scheduling tests;
- Scheduling appointments;
- Reporting normal test results;
- Recommending a referral to another physician;
- A consultative message exchange from a patient who is seen in-person immediately afterward as a result of the consultative message;
- A brief follow-up of an office visit, medical procedure or other treatment to confirm stable condition;
- A brief discussion to confirm stability of a chronic problem and continuity of present management of the problem; and
- All communications in connection with Mental Health or Substance Use Disorder Covered Services (as provided in section 5.6).

5.1.4 Telephone Visits

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

5.1.5 Administration of Anesthesia and Surgical Procedures

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

5.1.6 Immediate Care

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

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. See section 5.5 for coverage of Emergency Care and Urgent Care Services.

5.1.7 Retail Health Clinics

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, earaches, and sprains. Routine care, like periodic health exams and well-baby care, should be delayed until you can be seen by your Primary Care Provider. All Covered Services must be Medically Necessary and appropriate and received from Qualified Practitioners. Not all services are available at Retail Health Clinics.

5.2 PREVENTIVE SERVICES

Preventive Services are covered as shown in the Benefit Summary. For preventive Women's Health Care Services, see section 5.3.

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

- Services rated "A" or "B" by the U.S. Preventive Services Task Force, <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations>;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children and adolescents as supported by the Health Resources and Services Administration; and
- Preventive care and screenings for women as supported by the Health Resources and Services Administration, <http://www.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 5.2.1). If you need assistance understanding coverage for preventive Services under your Plan, please contact Customer Service at 503-574-7500.

5.2.1 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 screening services are covered when performed during a periodic health examination or well-baby care examination. In order for a child to be eligible for benefits for routine newborn baby care, the child must be properly enrolled as outlined in section 3. Ancillary Services, such as immunizations, are covered at the specified benefit level when billed by the provider.

Recommended Guidelines:

Infants up to 30 months: Up to 12 well-baby visits.

Children and Adolescents:

3 years through 21 years: One exam every year.

Adults:

22 years through 29 years: One exam every five years.

30 years through 49 years: One exam every two years.

50 years and older: One exam every year.

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

Preventive hearing screenings are covered as shown in your Medical Benefit Summary.

5.2.2 Immunizations and Vaccinations

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

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

5.2.3 Prostate Cancer Screening Exams

Plans Well-aware and Engaged, Well-aware, and Well

If you are covered under Plans Well-aware and Engaged, Well-aware or Well as an Active Member or Retiree, benefits for prostate cancer screening examinations include a digital rectal examination and a prostate-specific antigen test, every Calendar Year for men 50 and older, or as recommended by your Qualified Practitioner for men designated as high risk.

Early Retiree Plan If you are covered under the Early Retiree Plan, 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.

5.2.4 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; or
- 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.

Plans Well-aware and Engaged, Well-aware, and Well:

If you are covered under Plans Well-aware and Engaged, Well-aware or Well as an Active Member or Retiree, all Colorectal Cancer Screening Services are covered as stated on the Benefit Summary.

Early Retiree Plan: If you are covered under the Early Retiree Plan, coverage for Colorectal Cancer Screening Services is provided as follows:

For members age 45 and older:

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

For members under age 45:

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

5.2.5 Preventive Services for Members with Diabetes

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

- Every Calendar year 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; and
- Every five years a pneumococcal vaccine.

See section 5.2.6 for coverage of Diabetes Self-Management Services.

5.2.6 Diabetes Self-Management Education Program

Benefits are paid in-full for diabetes self-management 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 not more than three hours per year of assessment and training upon a material change of condition, medication or treatment. All services must be received from licensed providers and facilities, practicing within scope of license.

5.2.7 Nutritional Counseling

Nutritional counseling is covered when prescribed by a Qualified Practitioner, as shown in your Benefit Summary. Fasting and rapid weight loss programs are not covered.

5.2.8 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 Plan-approved programs is available online at [ProvidenceHealthPlan.com](https://www.providencehealthplan.com) (select "search" and enter "tobacco cessation") or by calling Customer Service at 503-574-7500 or 800-878-4445. Tobacco use cessation deterrents, including prescription and over-the-counter (OTC) medications are covered under your Prescription Drug Benefit, section 5.9, and must be purchased from Participating Pharmacies.

5.3 WOMEN'S HEALTH CARE SERVICES

Women may choose to receive Women's 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 advanced registered nurse practitioners specializing in women's health care, certified nurse midwives, and licensed direct entry midwives.

5.3.1 Gynecological Examinations

Benefits for gynecological examinations include breast, pelvic and pap examinations once every Calendar Year, or more frequently for women who are designated high risk. Family planning Services are separate (see section 5.3.3). Benefits also include follow-up exams for any medical conditions discovered during an annual gynecological exam that require additional treatment.

5.3.2 Mammograms

Mammograms are covered for women over 40 years of age once every Calendar Year. If the Member is designated high risk, mammograms are covered as recommended by the Primary Care Provider or Women's Health Care Provider. See section 5.8.12 for diagnostic and supplemental breast examinations.

5.3.3 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 Providence Health Plan's formulary.

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

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

For coverage of tubal ligation, see Elective Sterilization, section 5.8.14.

5.3.4 Maternity Services

Your benefits include coverage for comprehensive maternity care.

Your Benefit Summary lists your Member costs (Deductible, Copayment or Coinsurance) that apply to your pregnancy for all prenatal/postnatal office visits and delivery Services. This Copayment or Coinsurance does not apply to other Covered Services, such as laboratory and X-ray, 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.

Covered Services include:

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

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

**Newborn nursery care is a facility Service covered under the enrolled newborn's Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the enrolled newborn's Provider Inpatient visit benefit. See section 3.3.4 regarding newborn, newly adopted children, and newly fostered children eligibility and enrollment.

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

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 eligible and properly enrolled under this Plan within the time frames outlined in section 8.2.4 regarding Newborn Eligibility and Enrollment.

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

The services of a lay, unlicensed direct entry, 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 Network hospitals. Call the Providence Resource Line at 503-574-6595 or visit www.providence.org/classes for information on classes, specific dates, locations, registration and prices. Classes vary by geographic area. In addition, Members may receive support services through care or case management. A care manager may be a social worker and/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.

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

5.3.5 Breastfeeding Counseling and Support

Coverage for lactation counseling is provided when Medically Necessary as determined by the Qualified Practitioner. Lactation Counseling Services must be received from licensed providers. Benefits include coverage in full for Plan-approved breast pump equipment and supplies when rented or purchased through Network Medical Equipment Providers. Out-of-Network, benefits are subject to your DME benefits.

5.4 INPATIENT HOSPITAL AND SKILLED NURSING FACILITY SERVICES

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

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

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

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

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

5.4.1 Inpatient Hospital Services

Benefits are provided as shown in your Benefit Summary.

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

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

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, when necessary; 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.

5.4.2 Skilled Nursing Facility

Benefits are provided as shown in the Benefit Summary for Covered Services from a Skilled Nursing Facility. Services must be prescribed by your Qualified Practitioner in order to limit Hospital Confinement and provide convalescent skilled medical and nursing Services which cannot be adequately provided through a home health program. The cost of Medically Necessary transportation will be covered.

5.4.3 Inpatient Rehabilitative Care

Benefits are provided for physical, occupational and speech therapy Covered Services as shown in the Benefit Summary for inpatient rehabilitation 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 limits specified in the Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 5.8.3 for coverage of Outpatient Rehabilitation Services.)

5.4.4 Inpatient Habilitative Care

Coverage is provided, as shown in the Benefit Summary, for Medically Necessary inpatient habilitative care. If a Member is hospitalized when habilitative Services begin, habilitative benefits will begin on the day treatment becomes primarily habilitative. All Services must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. Coverage is provided at the same benefit level as Inpatient Rehabilitative Care listed in your Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 5.8.4 for coverage of Outpatient Habilitative Services.)

5.4.5 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.

5.5 EMERGENCY CARE AND URGENT CARE SERVICES

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

Service Area. If an emergency situation should occur, you should take immediate action and seek prompt medical care. You should call 911, or the emergency number listed in the local telephone directory or go to the nearest Hospital emergency department.

5.5.1 Emergency Care

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

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

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

Definitions:

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

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

“Emergency Services” means, with respect to an emergency medical condition:

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

services for medical or behavioral health conditions that is Medically Necessary to avoid placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

This Plan covers Emergency Care 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, 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 does not apply and all Services are subject to the Inpatient Services benefit shown in your Benefit Summary.

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

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

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

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

5.5.2 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. Coverage is provided as shown in the Benefit Summary and applies to each transport.

5.5.3 Emergency Eye Care Services

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

5.5.4 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 5.6.3, at the time Services are received. Prior Authorization is not required for emergency treatment; however, Providence Health Plan must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to an In-Network Provider for continued inpatient care, the cost of Medically Necessary transportation will be covered.

5.5.5 Urgent Care Services

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

Whenever you need Urgent Care, call your Primary Care Provider first. Your Primary Care Provider or the provider-on-call is always available, day or night. He or she may either suggest that you come to the office or go to an emergency room or Urgent Care Center.

You are responsible for the Urgent Care Copayment/Coinsurance, as shown in the Benefit Summary, whenever you receive Urgent Care Services. Please be prepared to pay the Copayment/Coinsurance at the time you receive care. You are also responsible for the applicable 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, your relative, or your designated representative, should call Providence Health Plan within 48 hours or as soon as reasonably possible.

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

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

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

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

5.6 MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

This Plan complies with federal Mental Health Parity.

5.6.1 Mental Health Services

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

Covered Services include diagnostic evaluation, individual and group therapy, inpatient hospitalization as stated in section 5.4, residential, day, intensive outpatient, or partial hospitalization Services. For inpatient, residential, day, intensive outpatient, or partial hospitalization treatment services; Providence Health Plan must be notified as soon as reasonably possible following the onset of treatment for coverage to continue.

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

5.6.2 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 Providence;
- Benefits include coverage of any other non-excluded mental health or medical services identified in the individualize treatment plan;
- Treatment must be provided by a health care professional licensed to provide ABA Services; and
- Treatment may be provided in the Member's home or in a licensed health care facility.

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

Exclusions to ABA Services:

- Services provided by a family or household member;
- Services that are custodial in nature, or that constitute marital, family, or training services;
- Services that are educational or correctional that are provided by a school or halfway house or received as part of an education or training program;
- Custodial or respite care, creative arts therapy, wilderness or adventure camps, social counseling, music therapy, chelation or hyperbaric chambers;

- Services provided under an individual education plan in accordance with the Individuals with Disabilities Education Act;
- Services provided through community or social programs; and
- Services provided by the Department of Human Services or the Oregon Health authority, other than employee benefit plans offered by the department and the authority.

5.6.3 Substance Use Disorder Services

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

Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 5.4, residential, day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by us.

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

Common formulations of medications for medication assisted treatment such as buprenorphine and naltrexone are a covered benefit when medically necessary. Benefits are provided as shown in the benefits summary. Treatments involving the use of methadone are a Covered Service only when such treatment is part of an approved medically-supervised treatment program.

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

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

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

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

5.7.1 Medical Supplies (Including Diabetes Supplies)

Benefits are provided as 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, catheters, 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 In-Network 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 5.7.4 for coverage of diabetic equipment such as insulin pump devices.
3. Medically Necessary Medical Foods for supplementation or dietary replacement including non-prescription elemental enteral formula for home use, when determined to be Medically Necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition. Medical foods are also covered for the treatment of Inborn Errors of Metabolism, as described in section 5.8.11. Medical foods do not include total parenteral nutrition (TPN), which is covered under section 5.8.1.

5.7.2 Medical Appliances

Benefits are 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, and do not apply to your Deductible.
5. Medical devices that are surgically implanted into the body to replace or aid function (including bilateral cochlear implants). If you receive a procedure to implant a medical device, you will be responsible for any Copayment or Coinsurance for the medical device in addition to any Copayment or Coinsurance for the procedure.
6. Other Medically Necessary appliances, including Hearing Aids and Hearing Assistance Technology (HAT), as ordered by your Qualified Practitioner.

5.7.3 Prosthetic & 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 5.7.3).

5.7.4 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 Providence Health Plan.

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

5.8 OTHER COVERED SERVICES

5.8.1 Outpatient Hospital Services, Dialysis, Chemotherapy and Radiation Therapy, and Multidisciplinary Pain Management Programs

Benefits are provided as shown in the Benefit Summary and include outpatient Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 5.8.6 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 and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, therapeutic procedures, and approved multidisciplinary pain management programs as ordered by your Qualified Practitioner. We may require that you obtain a second opinion for some elective procedures. If you do not obtain a second opinion when requested, Providence Health Plan will not Prior Authorize the Services. For additional information about Prior Authorization, see section 4.4.

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

Covered Services under these benefits do not include Services for Outpatient Rehabilitation. See section 5.8.3 for those Services.

5.8.2 Self-Administered Chemotherapy

Self-administered chemotherapy agents, including oral medications and injectable medications, are covered when received from a Network retail or specialty pharmacy under your Outpatient Chemotherapy benefit. Self-administered chemotherapy will be covered under your Prescription Drug Benefit when that coverage results in a lower out-of-pocket expense to the Member.

5.8.3 Outpatient Rehabilitation Services

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

- Services must be Medically Necessary;
- Services must be provided by a physician or licensed/registered therapist to restore or improve lost function following illness or injury.
- Prior Authorization is received by Providence
- 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. A visit is considered 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). Limits do not apply to Mental Health Covered Services.

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

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

Exclusions to Outpatient Rehabilitation Services:

1. Chiropractic adjustments and manipulations of any spinal or bodily area;
2. Exercise programs;
3. Rolfing, polarity therapy and similar therapies; or
4. Rehabilitation Services provided under an authorized home health care plan, as stated in section 5.8.12.

See section 5.4.3 for coverage of Inpatient Rehabilitation Services.

5.8.4 Outpatient Habilitation Services

Coverage is provided, as shown in the Benefit Summary, for Medically Necessary outpatient habilitative Services. All Services are subject to review for Medical Necessity and must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. Coverage is provided at the same benefit level as Outpatient Rehabilitative Care listed in your Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 5.4.4 for coverage of Inpatient Habilitative Services.)

5.8.5 Allergy Shots and Allergy Serums

Allergy shots and allergy serums 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.

5.8.6 Injectable and Infused Medications

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

5.8.7 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 5.7.2 (Medical Appliances). Covered Services do not include routine foot care and the removal of corns or calluses, unless you have diabetes.

5.8.8 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 6.2. This exclusion does not apply to Mental Health or Substance Use Disorders.

5.8.9 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:

1. All stages of reconstruction of the involved breast following a mastectomy;
2. Surgery and construction of the other breast to produce a symmetrical appearance;

3. Prostheses; and
4. Treatment of physical complications of all stages of mastectomy, including lymphedemas.

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

5.8.10 Outpatient 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), imaging (such as PET, CT, MRI and MRA), radiology (X-ray) tests and other Medically Necessary diagnostic procedures. Covered Services include contrast materials (dyes) that may be required for a diagnostic procedure. All PET, CT, CTA, MRI and MRA imaging Services, Nuclear Cardiac Study Services, and echocardiography Services must be Prior Authorized by Providence Health Plan or their authorizing agent.

5.8.11 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.

5.8.12 Diagnostic and Supplemental Breast Examinations

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

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

See section 5.3.2 for annual preventive mammograms.

5.8.13 Inborn Errors of Metabolism

The Plan 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 5.7.1.

5.8.14 Home Health Care

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

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

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

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

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

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

Home health care benefits do **NOT** include:

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

5.8.15 Hospice Care

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

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:

1. Nursing care provided by or under the supervision of a registered nurse;
2. 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;
3. Services provided by your Qualified Practitioner or a physician associated with the hospice program;
4. 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;
5. 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;
6. Rehabilitation therapies provided for purposes of symptom control or to enable you to maintain activities of daily living and basic functional skills; and
7. 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 and other Services not specified above are excluded from coverage.

5.8.16 Elective Sterilization

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

All Covered Services must be received from Qualified Providers and Facilities.

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

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.

5.8.17 Hearing Loss Services

Definitions:

Cochlear Implant

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

Hearing Aid

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

Covered Services:

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

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

Cochlear implants:

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

Hearing aids & related accessories:

Medically Necessary external hearing aids and devices, as prescribed, fitted, and dispensed by a licensed audiologist or a hearing aid/instrument specialist. Hearing aids and devices are covered under the Medical Appliances benefit. This benefit is available for one hearing aid per ear every 3 Calendar Years for all Members. Hearing aid batteries are covered for one box per hearing aid per Calendar Year. These services and devices are not subject to your Deductible in-network.

Diagnostic & Treatment Services:

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

Hearing Assistance Technology

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

Limits to Hearing Loss Services

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

5.8.18 Wigs

This Plan will provide coverage for one wig every calendar year for Members who have undergone chemotherapy or radiation therapy or are experiencing pharmaceutical drug-induced Alopecia at the Medical Equipment, Supplies and Devices benefit level listed in your Benefit Summary. A wig is a full cranial hair prosthesis to use as a hair loss solution or hair replacement. Wigs may be purchased from any wig supplier. Wig suppliers may require

Members to pay for items and submit the paid receipt to Providence Health Plan for reimbursement. For information about submitting claims, see section 8.1.1.

5.8.19 Chiropractic Manipulation

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

5.8.20 Acupuncture

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

5.8.21 Massage Therapy

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

5.8.22 Biofeedback

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

5.8.23 Fertility Preservation Services

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

Covered Services include the following:

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

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

5.8.24 Vision Therapy

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.

5.9 PRESCRIPTION DRUG BENEFIT

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

DEFINITIONS

Self-Administered Prescription Drug

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

The following are considered “Prescription Drugs”:

1. Any medicinal substance which bears the legend, “RX ONLY” or “Caution: federal law prohibits dispensing without a prescription”;
2. Insulin;
3. Any medicinal substance of which at least one ingredient is a federal or state 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 may be subject to your Allergy Shots and Allergy Serums benefit (see section 5.8.5). For details about Injectable and Infused Medications, refer to sections 5.8.6, 5.8.1, and 5.9.1.

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

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.

Formulary

Formulary means a list of preferred brand-name and generic drugs that have been evaluated by Providence Health Plan for effectiveness and safety.

Maintenance Drugs

Maintenance Drugs means medications that are typically prescribed to treat long-term or chronic conditions, such as diabetes, high blood pressure and high cholesterol.

Maintenance drugs are those that you have received under our Plan for at least 30 days and that you anticipate continuing to use in the future.

5.9.1 Using Your Prescription Drug Benefit

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

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

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

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

- Please present your Member ID Card to the Participating Pharmacy at the time you request Services. If you have misplaced or do not have your Member ID Card with you, please ask your pharmacist to call Providence Health Plan.
- Prescription Drug Services are subject to the Copayments or Coinsurance listed in your Prescription Drug Benefit Summary.
- If you are enrolled under Plans Well-aware and Engaged, Well-aware or Well as an Active Member or Retiree, Prescription Drug Copayments and Coinsurance apply to your Calendar Year Medical Out-of-Pocket Maximum.
- If you are enrolled under Plans Well-aware and Engaged, Well-aware or Well as an Active Member or Retiree, any difference in cost for Prescription Drug Covered Services does not apply to the Medical Deductible or Medical Out-of-Pocket Maximum.
- If you are enrolled under the Early Retiree Plan, your Common Medical/Pharmacy Deductible must be met before benefits will be provided for Prescription Drug Covered Services.
- If you are enrolled under the Early Retiree Plan, Prescription Drug Copayments and Coinsurance apply to the Common Out-of-Pocket Maximum.
- If you are enrolled under the Early Retiree Plan, any difference in cost for Prescription Drug Covered Services does not apply to the Common Medical/Pharmacy Deductible or Common Out-of-Pocket Maximum.

- The amount paid by a manufacturer discount and/or copay assistance programs will apply towards your Calendar Year Deductibles and Out-of-Pocket Maximums, except for amounts paid under the Specialty Pharmacy Variable Copay Program.
- 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 or your provider 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.
- Participating Pharmacies may not charge you more than your Copayment or Coinsurance. Please contact Customer Service if you are asked to pay more or if you or the pharmacy have questions about your prescription drug benefits or need assistance processing your prescription.
- Copayments or Coinsurance are due at the time of purchase.
- 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 drugs 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 the prescription or you can mail your prescription along with your Providence Health Plan Member ID number to one of our Participating mail-order pharmacies. To find our Participating mail-order pharmacies please visit our website at ProvidenceHealthPlan.com/pharmacy. (Not all prescription drugs are available through our mail-order pharmacies.)
- 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 the Plan's medical supplies and devices benefits, limitations and Copayments and/or Coinsurances. See section 5.7 and your Benefit Summary. Diabetes supplies do not include insulin pump devices, which are covered under your Durable Medical Equipment Benefit, section 5.7.4.
- Select self-administered injectable medications are not covered when supplied in a provider's office, clinic or facility. Medications listed on the Self-Administered Drug list may be administered by a healthcare provider in a provider's office, clinic, or facility for a transition period, and benefits in section 5.8.6 apply. Please refer to the Providence Pharmacy Resource website at ProvidenceHealthPlan.com/pharmacy for the Self-Administered Drug list. After this transition period, you will need to self-administer at home and your prescription drug benefit applies.
- Injectable medications received in your provider's office are covered under section 5.8.6.
- Infusions, including infused medications, received at Outpatient Facilities are covered under section 5.8.1.
- 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 the Prescription Drug

Formulary available at ProvidenceHealthPlan.com/pharmacy or by contacting Customer Service.

- 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.

5.9.2 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 and submit a request to Providence Health Plan for reimbursement.

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

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

5.9.3 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 medication 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 drug to dispense. See Section 8.1.1 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.

5.9.4 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 Prescription Drug Benefit Summary for your Prescription Drug Copayment or Coinsurance information.

If you or your provider request a brand-name drug when a generic is available, regardless of the reason or Medical Necessity, you will be responsible for paying the cost difference in addition to your brand-name Copayment or Coinsurance. Your total cost, however, will never exceed the actual cost of the drug. The difference in cost between the brand-name and generic drug will not be applied toward your Out-of-Pocket Maximum, and you will continue to be responsible for the difference in cost after your Out-of-Pocket Maximum is met. If your brand-name drug is authorized through formulary exception and our formulary includes a generic equivalent, you will be responsible for the difference in cost between the brand-name and the generic drug and the difference in cost will apply toward your Calendar Year Deductible and Out-of-Pocket Maximum.

Affordable Care Act Preventive Drugs

In accordance with the Affordable Care Act (ACA), your Plan covers, at no cost to you, certain preventive medications, including contraceptives, both prescription and Over-the-counter, when these medications are purchased from Participating Pharmacies. ACA preventive drugs 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. However, over the counter contraceptives do not require a written prescription pursuant to Oregon state law.

5.9.5 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 of our Participating Pharmacies; and
6. Opioids up to 7 days initial dispensing.

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

5.9.6 Participating Mail-Order and Preferred Retail Pharmacies

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

5.9.7 Specialty Pharmacy Variable Copay Program

Many specialty medications have manufacturer programs which provide financial assistance to patients in the purchase of the medication. When a financial assistance program is available from a prescription drug manufacturer for a specialty medication, SAIF Corporation requires that you participate in the program. Failure to complete the enrollment process for participation will result in a higher copayment/coinsurance and/or penalty, which can exceed the regular plan benefit cost shares. Manufacturer-funded financial assistance will not be considered true out of pocket costs for plan participants and will not apply to out of pocket deductible maximums. Only your actual out-of-pocket payments will count toward your deductible or out-of-pocket maximum. For medications not subject to this program, regular plan benefits will apply. Due to federal regulation, Health Savings Account (HSA) plans are not eligible for this program.

5.9.8 Prescription Drug Limitations

Prescription drug limitations are as follows:

1. All drugs must be Food and Drug Administration (FDA) approved, Medically Necessary and require by law a prescription to dispense. Not all FDA approved drugs are covered under this Plan. Newly approved drugs will be reviewed for safety and medical necessity within 12 months after the drug becomes available on the market for Formulary consideration.
2. Certain drugs require Prior Authorization for Medical Necessity, place of therapy, length of therapy, step therapy, number of doses or dispensing limits. Step therapy uses our pharmacy claims history to confirm if certain drugs have been tried first by a Member. If a drug has not been tried first, cannot be tried first, or if the drug history is not available, Prior Authorization is required. For some drugs, Providence Health Plan will limit the amount of the drug the Plan will cover. Please have your provider contact Providence Health Plan for Prior Authorization. If you have questions regarding a specific drug, please call Customer Service.
3. Specialty drugs are injectable, infused, oral or inhaled therapies that often require specialized delivery, handling, monitoring and administration and are generally high cost. These drugs must be purchased through Providence Health Plan's designated specialty pharmacy. Due to the nature of these medications, they are not considered

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

5.9.9 Prescription Drug Exclusions

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

1. Drugs or medicines delivered, injected or administered to you by a physician or other provider or another trained person (see section 5.8.6);
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;
4. Fluoride, for Members over 16 years of age;
5. Drugs that are not provided in accordance with Providence Health Plan's Formulary management program or are not provided according to Providence Health Plan's 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 repackaging, 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 or 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. Drugs that are not FDA-approved or are designated as "less than effective" by the FDA (also known as "DESI" drugs);
18. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC;
19. Early refill of eye drops, except when there is a change in directions by your provider, or if synchronizing your prescription refills. This exclusion does not apply to eye drops prescribed for the treatment of glaucoma; and
20. For drugs obtained at in-network pharmacies without using your pharmacy benefit, reimbursement is limited to our in-network contracted rates, except in the case of Urgent/Emergent situations. This means you may not be reimbursed the full cash price you pay to the pharmacy. Drugs obtained from out-of-network pharmacies are not eligible for reimbursement, except in the case of Urgent/Emergent situations.

5.9.10 Prescription Drug Disclaimer

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

6. LIMITED COVERED SERVICES

There are limitations on the benefits available under this Plan for the treatment of certain conditions and the use of certain procedures. These limitations are described in this section.

6.1 HUMAN ORGAN/TISSUE TRANSPLANTS

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

- Removed from the body of one person (the donor) and implanted in the body of another person (the recipient who is a 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.

6.1.1 Covered Services

Covered Services for transplants are limited to Services that:

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

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

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

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

6.1.2 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.

6.1.3 Benefits for Outpatient Medications

Outpatient prescription medications for transplant-related Services, including anti-rejection (immunosuppressive) drugs, are eligible for reimbursement under your Prescription Drug Benefit. See section 5.9.

6.1.4 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 Deductible, 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.

6.1.5 Transplant Prior Authorization

(See also section 4.4.)

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

- Initial consultation;
- Evaluation;
- Transplant facilities;
- Donor evaluation;
- Donor Services;
- High-dose chemotherapy administered prior to the transplant;

- HLA typing;
- Travel expenses;
- Pre-transplant care;
- Self-donation Services;
- Transplant Services; and
- Follow-up treatment.

6.1.6 Transplant Exclusions

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

- Any transplant procedure performed at a transplant facility that has not been approved by Providence Health Plan;
- Any transplant that is Investigational, as determined by Providence Health Plan;
- Services or supplies for any transplant that are not specified as Covered Services in section 6.1, such as transplantation of animal organs or artificial organs;
- Outpatient medications and anti-rejection (immunosuppressive) drugs, unless this Plan includes a prescription drug Endorsement;
- Services related to organ/tissue donation by a Member if the recipient is not a Member or the Member/recipient is not eligible for transplant benefits under this Plan; and
- Transplant-related travel expenses for the donor and the donor's and recipient's family members.

6.2 RESTORATION OF HEAD/FACIAL STRUCTURES; LIMITED DENTAL SERVICES

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

Restoration Services are covered under the applicable benefit level listed in the Benefit Summary based upon the type of Services received.

Exclusions that apply to Covered Services include:

- Cosmetic Services not considered medically necessary;
- Services rendered to improve a condition that falls within the normal range of such conditions;
- Routine Orthodontia;
- Services to treat tooth decay, periodontal conditions and deficiencies in dental hygiene;
- Removal of impacted teeth;
- The making or repairing of dentures;

- Orthognathic surgery to treat developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth; and
- Services to treat temporomandibular joint syndrome, including orthognathic surgery, except as specified in section 6.2.1.

6.2.1 Temporomandibular Joint (TMJ) Services

Benefits are provided for TMJ Services using your In-Network benefits as shown in the Benefit Summary. Covered Services include:

1. A diagnostic examination including a history, physical examination and range of motion measurements, as necessary;
2. Diagnostic X-rays;
3. Physical therapy of necessary frequency and duration;
4. Therapeutic injections;
5. Therapy utilizing an appliance/splint which does not permanently alter tooth position, jaw position or bite. Benefits for this therapy will be based on the use of a single appliance/splint, regardless of the number of appliances/splints used in treatment. Coverage of the appliance/splint is under the provisions of this section and coverage is not applicable under section 5.7.2 (Medical Appliances). The benefit for the appliance splint therapy will include an allowance for diagnostic Services, office visits and adjustments; and
6. Surgical Services.

TMJ Services are covered as shown in your Benefit Summary; limits may apply. Out-of-Network benefits do not apply to TMJ Services. Covered Services for TMJ conditions do not include dental or orthodontia Services.

6.2.2 Outpatient Hospitalization and Anesthesia for 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.

6.3 GENETIC TESTING AND COUNSELING SERVICES

Genetic testing and counseling are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature.. Select genetic testing requires Prior Authorization, for more information see section 4.4.

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

6.4 BARIATRIC SURGERY SERVICES

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

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

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

6.5 GENDER DYSPHORIA

Benefits are provided for gender affirming Services for the treatment of Gender Dysphoria as determined by our medical policy. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and select surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply to certain inpatient procedures. Please see section 4.4 for more information on services requiring Prior Authorization.

6.6 FERTILITY SERVICES

Coverage for Fertility Services is provided as shown in the Medical Benefit Summary for other office procedures.

Covered Services include the following:

- Diagnostic testing and associated office visits to determine the cause of infertility. This includes the physical examination, related laboratory testing, instruction, and medical/surgical procedures when performed for the sole purpose of diagnosing an infertile state. Diagnostic Services for infertility include, but are not limited to, hysterosalpingogram, laparoscopy and pelvic ultrasound.
- Assisted Reproductive Technology (ART), including egg/sperm freezing and storage, is covered regardless of diagnosis;
- Artificial insemination, limited to a lifetime maximum of six (6) cycles and sperm wash;
- Cost of acquiring semen;
- Infertility related drugs or injectables;

- Covered infertility-related supplies;
- Charges for donor semen from donor banks or other providers;
- Charges for harvesting and storage of semen other than for immediate use; and
- Coverage for in vitro and in vivo fertilization, including Services or medications related to or supporting in vitro fertilization, GIFT, or ZIFT.

NOTE: Covered Services are subject to an annual maximum benefit limit of \$20,000 for medical, and \$10,000 for pharmacy. The lifetime maximum benefit for these services is \$40,000.

Covered Services do NOT include:

- All Services for non-Participant surrogate mothers;
- Infertility resulting from the aging process as confirmed by elevated FSH;
- Reversals of voluntary sterilization; and
- Procedures determined to be experimental or investigational.

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

6.7 GENE AND ADOPTIVE CELLULAR THERAPY

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

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

7. EXCLUSIONS

In addition to those Services listed as not covered in sections 5 and 6, the following are specifically excluded from coverage under this Plan.

General Exclusions:

The Plan does 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 or after coverage terminates;
- 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 5.5;
- 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 in the custody of any law enforcement authorities or while incarcerated, except as provided in section 4.3;
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos, books and educational programs to which drivers are referred by the judicial system and volunteer mutual support groups;
- Are provided to yield primarily educational outcomes, unless medically necessary or as otherwise covered under the Preventive Services benefit described in section 5.2. An outcome is “primarily educational” if the outcome’s fundamental, first, or principal character is to provide you with enduring knowledge, skill, or competence through a process of repetitive positive reinforcement over an extended length of time. An outcome is “enduring” if long-lasting or permanent;
- Are performed in association with a Service that is not covered under this Plan, except Emergency Services;
- Are provided for any injury or illness that is sustained by an Eligible Employee or a Family Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers’ Compensation Act or similar law is required for the Eligible Employee or Family Member. This exclusion also applies to injuries and illnesses that are the subject of a claim settlement or claim disposition agreement 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. Any benefits or Services provided under this Plan that are subject to this exclusion are provided solely to assist you and such assistance does not waive our right to reimbursement or subrogation as specified in section 8.4. This exclusion also applies

to Services and supplies after you have received proceeds from a settlement as specified in section 8.4.3;

- Are provided in a facility that specializes in treatment of developmental disabilities, except as provided in section 5.6.2;
- Are provided for treatment or testing required by a third party or court of law which is not Medically Necessary;
- Are Investigational;
- Are determined by Providence Health Plan not to be Medically Necessary for diagnosis and treatment of an injury or illness;
- Are received by a Member under the Oregon Death with Dignity Act; 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 one 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 a medical condition (i.e., a physical or mental health condition), This exclusion does not apply to Mental Health or Substance Use Disorder services.

The Plan does not cover:

- Charges that are in excess of the Usual, Customary and Reasonable (UCR) charges;
- Custodial Care;
- Transplants, except as provided in section 6.1;
- Services for Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, Durable Medical Equipment (DME), except as described in section 5.7;
- Charges for Services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to, air conditioners, air purifiers, vacuum cleaners, motorized transportation equipment, escalators, elevators, tanning beds, ramps, waterbeds, hypoallergenic mattresses, cervical pillows, swimming pools, whirlpools, spas, exercise equipment, gravity lumbar reduction chairs, home blood pressure kits, personal computers and related equipment or other similar items or equipment;
- Physical therapy and rehabilitation Services, except as provided in sections 5.4.3 and 5.8.3;
- “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 5.1.2;
- “Get acquainted” visits without physical assessment or diagnostic or therapeutic intervention provided and online treatment sessions;
- Missed appointments;
- Non-emergency medical transportation;
- Allergy shots and allergy serums, except as provided in section 5.8.5;
- All Services and supplies related to the treatment of obesity or morbid obesity, except as provided in sections 5.2.7, 5.6.1 and when added to this Plan as a Supplemental Benefit in section 6.4;

- 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 sections 5.2.8 and 6.4;
- Transportation or travel time, food, lodging accommodations and communication expenses except as provided in sections 4.5 and 6.1 and with Prior authorization;
- Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
- Biofeedback, except as provided in section 5.8.20;
- Thermography;
- Homeopathic procedures;
- Comprehensive digestive stool analysis, cytotoxic food allergy test, dark-field examination for toxicity or parasites, EAV and electronic tests for diagnosis and allergy, fecal transient and retention time, Henshaw test, intestinal permeability, Loomis 24-hour urine nutrient/enzyme analysis, melatonin biorhythm challenge, salivary caffeine clearance, sulfate/creatinine ratio, urinary sodium benzoate, urine/saliva pH, tryptophan load test, and zinc tolerance test;
- Chiropractic manipulation and acupuncture, except as provided in sections 5.8.17 and 5.8.18;
- 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 and counseling are excluded, except as provided in section 6.3. 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 5.2.8 or when provided as Extra Values or Discounts, where available;
- Cosmetic Services including supplies and drugs not considered medically necessary;
- Services, including routine physical examination, immunizations and vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel;
- Non-sterile examination gloves;
- Sales taxes, handling fees and similar surcharges, as explained in the definition of UCR;
- Air ambulance transportation for non-emergency situations is not covered, except as provided in section 5.5.2;
- Treatments that do not meet the national standards for Mental Health/Substance Use Disorder professional practice;
- Services provided under a court order or as a condition of parole or probation or instead of incarceration unless Medically Necessary;
- Personal growth Services such as assertiveness training or consciousness raising;
- School counseling and support Services, peer support Services, tutor and mentor Services; independent living Services, household management training, and wraparound services that are provided by a school or halfway house and received as part of an educational or training program;

- Recreation services, therapeutic foster care, wraparound services, emergency aid for household items and expenses; Services to improve economic stability, and interpretation Services;
- Evaluation or treatment for education, professional training, employment investigations, and fitness for duty evaluations;
- Community Care Facilities that provide 24 hour non-medical residential care;
- Counseling related to family, marriage, sex and career including, but not limited to, counseling for adoption, custody, family planning or pregnancy. This exclusion does not apply to Mental Health or Substance Use Disorder.;
- Neurological Services and tests including, but not limited to, EEGs; PET, CT and MRI imaging Services, and beam scans (except as provided in section 5.8.9);
- 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, or certified professional midwives; and
- Services of any unlicensed providers.

Exclusions that apply to Reproductive Services:

- All Services related to sexual disorders or dysfunctions regardless of gender or cause, except as provided in section 6.2. (This exclusion does not apply to Mental Health Covered Services);
- Termination of pregnancy, unless there is a severe threat to the mother, or if the life of the fetus cannot be sustained;
- All services for non-Member surrogate mothers;
- All services associated with surrogate parenting, including Infertility testing and treatment;
- Reversal of voluntary sterilization; and
- Services provided in a premenstrual syndrome clinic or holistic medicine clinic.

Exclusions that apply to Vision Services:

- Surgical procedures which alter the refractive character of the eye, including, but not limited to laser eye surgery, radial keratotomy, myopic keratomileusis and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia, hyperopia or astigmatism;
- Services for routine eye care and vision care, vision exams/screenings, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in sections 5.2.5, 5.5.3 and 5.7.2; and
- Vision training, except as provided in section 5.8.21.

Exclusions that apply to Hearing Services:

- Hearing aids, hearing therapies and/or devices, except as provided in section 5.8.15.

Exclusions that apply to Dental Services:

- Oral surgery (non-dental or dental) or other dental Services (all procedures involving the teeth; wisdom teeth; areas surrounding the teeth; dental implants), except as approved by Providence Health Plan and described in section 6.2;
- Services for temporomandibular joint syndrome (TMJ) and orthognathic surgery, except as approved by Providence Health Plan and described in section 6.2.1; and
- Dentures and orthodontia.

Exclusions that apply to Foot Care Services:

- Routine foot care, such as removal of corns and calluses, except for Members with diabetes; and
- Services for orthotics, insoles, arch supports, heel wedges, lifts and orthopedic shoes, except as described in section 5.7.2 (Medical Appliances).

Exclusions that apply to Prescription Drugs, Medicines and Devices:

- In addition to the exclusions listed in section 5.18.8; any drug, medicine, or device that does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Pre-market Approval, or 510K.

8. CLAIMS ADMINISTRATION

This section explains how the Plan treats 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 this Plan.

8.1 CLAIMS PAYMENT

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

Explanation of Benefits (EOB)

You will receive an EOB from Providence Health Plan after your claim has been processed. 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, services or amounts not covered and general information about our processing of your claim are explained on an EOB.

Timeframes for Processing Claims

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

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

- **For Prior Authorization of services that do not involve urgent medical conditions:** You and your provider will be notified of Providence Health Plan's decision within two business days after the Prior Authorization request is received. If 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 their review and provide written notice of its decision to the Member and the provider. If the information is not received within 15 days, the request will be denied.

- **For Prior Authorization of services that involve urgent medical conditions:** You and your provider will be notified of Providence Health Plan's decision within 72 hours after the Prior Authorization request is received. If additional information is needed to complete the review, the requesting provider or you will be notified within 24 hours after the request is received. The requesting provider or you will then have 48 hours to submit the additional information. The review will then be completed and the requesting provider or you will be notified of Providence Health Plan's 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 under the Plan and it is determined through Concurrent Review procedures to reduce or terminate that course of treatment, Providence Health Plan will provide advance notice to you of that decision. You may request a reconsideration of the decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. You will then be notified of Providence Health Plan's reconsideration decision within 24 hours after your request is received.

8.1.1 Timely Submission of Claims

The Plan will make no payments for claims received more than 365 days after the date of Service. Exceptions will be made if Providence Health Plan receives 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 will be made in accordance with ORS 743B.470.

Payment of all claims will be made within the time limits required by OAR 836-080-0235.

Please send all claims to:

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

8.1.2 Right of Recovery

The Plan has the right, upon demand, to recover from a recipient the value of any benefit or claim payment that exceeded the benefits available under this Plan. This right of recovery applies to any excess benefit, including (but not limited to) benefits obtained through fraud, error, or duplicate coverage relating to any Member. If timely repayment is not made, the Plan has 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 the Plan under any contract.

8.2 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 govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

8.2.1 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.

Each contract for coverage listed under (1) or (2) below 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.

1. Plan includes: group health 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.

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 8.2.2 determine whether This Plan is a Primary plan or Secondary plan when a Member has health care coverage under more than one Plan.

When this Plan is primary, we determine payment for our benefits first before those of any other Plan without considering any other Plan’s benefits. When this Plan is secondary, we

determine our benefits after those of another Plan and may reduce the benefits we pay so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense

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

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

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

Closed panel plan

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

Custodial parent

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

8.2.2 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. If the Primary plan is a Closed panel plan and the secondary plan is not a Closed panel plan, the Secondary plan shall pay or provide benefits as if it were the Primary plan when a covered person uses a non-panel provider, except for Emergency Services or authorized referrals that are paid or provided by the Primary plan.
 1. Except as provided in Paragraph (2) below, a Plan that does not contain a COB provision that is consistent with the State of Oregon's COB regulations is always primary unless the provisions of both Plans state that the complying Plan is primary.
 2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.
- B. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
- C. Each Plan determines its order of benefits using the first of the following rules that apply:
 1. Non-Dependent or Dependent. The Plan that covers a 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; orif 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, 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 person 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.

8.2.3 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.

8.2.4 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.

8.2.5 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.

8.2.6 Right of Recovery

If the amount of the payments made by us is more than we should have paid under this COB section, This Plan may recover the excess from one or more of the persons This Plan has 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.

8.3 COORDINATION WITH MEDICARE

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

In accordance with the “working aged” provisions of the Medicare Secondary Payer Manual, when the Employer Group’s size is less than 20 employees, for Members who are entitled to and enrolled in Medicare Part A, enrollment in Medicare Part B will be assumed and Medicare will be the primary payer and This Plan will coordinate benefits as the secondary payer even if the Medicare-eligible Member has not elected Medicare Part B.

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

Counting individuals for the Employer size:

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

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

8.4 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 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 group insurance (including student plans) whether under the Member’s policy or not, are subject to recovery by the Plan as a third-party recovery. Failure by the Member to comply with the terms of this section will be a basis for the Plan to deny any claims for benefits arising from the condition or to terminate the Member’s coverage under this Plan as specified in section 10.3. In addition, you or the Member must execute and deliver to the Plan 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.

8.4.1 Third-Party Liability/Subrogation and How it Affects You

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

If claim payments are made on any Member's behalf for any condition for which a third party is responsible, the Plan is 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 the Plan may collect directly from the third party to the extent the Plan has paid for third-party liabilities. Because the Plan has paid for the Member's injuries, the Plan, rather than the Member, is entitled to recover those expenses. Prior to accepting any settlement of the Member's claim against a third party, the Member must notify Providence Health Plan in writing of any terms or conditions offered in settlement and must notify the third party of the Plan's 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 the Plan 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 Providence Health Plan 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 Customer Service. 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.

8.4.2 Proceeds of Settlement or Recovery

Subject to paragraph 8.4.4 below, if for any reason the Plan is not paid directly by the third party, the Plan is 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, the Plan is 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 the Plan, 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, the Plan is entitled to the proceeds whether or not the loss is deemed to be compensable under the workers' compensation laws. The Plan is entitled to recover up to the full value of the benefits provided by it for the condition, calculated using Providence Health Plan's UCR charges for such Services, less the Plan's pro-rata share of the Member's out-of-pocket expenses and attorney fees incurred in making the recovery. The Plan is 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. The Plan is entitled to first priority in repayment, over the Member and over any other person, for such charges.

By accepting benefits under this Plan, the Member acknowledges our first priority to this repayment and assigns to the Plan any benefits the Member may have from other sources. The Member must cooperate fully with the Plan and Providence Health Plan 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 the trust agreement provided by Providence Health Plan, 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. The Plan may withhold benefits for the Member's condition until a signed copy of this agreement is delivered to Providence Health Plan. 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.

8.4.3 Suspension of Benefits and Reimbursement

Subject to paragraph 8.4.4 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 the Plan would otherwise be required to pay under this Plan until all proceeds from the settlement or recovery have been exhausted. If the Member has failed to reimburse us as required by this section, we are entitled to offset future benefits otherwise payable under this Plan or under any future 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, the Plan is not required to provide coverage for continuing treatment until the Member proves to Providence Health Plan's 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. The Plan will only cover the amount by which the total cost of

benefits that would otherwise be covered under this Plan, calculated using Providence Health Plan's UCR charges for such Services, exceeds the amount received in settlement or recovery from the third party. The Plan is entitled to suspend such benefits even if the total amount of such settlement or recovery does not fully compensate the Member for other damages, particularly including lost wages or pain and suffering.

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

8.4.4 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 8.4.2 and 8.4.3 above are modified as provided below.

Before the Plan will be entitled to recover from under 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 possibility 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.

9. PROBLEM RESOLUTION

9.1 INFORMAL PROBLEM RESOLUTION

All of the 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 Providence Health Plan help. Your Customer Service representative is available to provide information and assistance. You may call or meet with Providence Health Plan 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 Customer Service so we may help you with whatever special needs you may have.

9.2 MEMBER GRIEVANCE AND APPEAL

Definitions:

Adverse Benefit Determination

An Adverse Benefit Determination means a:

- Denial of eligibility for or termination of enrollment in this Plan;
- Rescission or cancellation of coverage under this Plan;
- Imposition of a Pre-existing Condition exclusion, source-of injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise Covered Services;
- Determination that a health care item or service is Investigational or not Medically Necessary; or
- Determination that a course 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.

9.2.1 Your Grievance and Appeal Rights

If you disagree with Providence Health Plan's decision about your medical bills or health care services, you have the right to two levels of internal review. You may request review if you have received an Adverse Benefit Determination. You may also file a quality of care or general complaint or Grievance with Providence Health Plan. 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 all documents, records, and other information relevant to our decision at any time before, during, or after the appeal process. This includes the specific internal rule, guidelines, protocol, or other similar criterion relied upon to make the Adverse Benefit Determination, as well as a copy of your claim or appeal file as applicable.
- You also have the right to request free of charge, at any time, the diagnostic and treatment codes and their meanings that are the subject of your claim or appeal.

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

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

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. Providence Health Plan will let you know by phone and letter if your case qualifies for an expedited review. If it does, Providence Health Plan will notify you of our decision within 72 hours of receiving your request.

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

9.2.2 Internal Grievance or Appeal

You must file your internal Grievance or Appeal within 180 days of the date on the notice of initial Adverse Benefit Determination, or that initial determination will become final. The 180-day timeframe applies to both Standard and Expedited appeals. Please provide Providence Health Plan any additional information that you want considered during the review process. If you are seeing an Out-of-Network Provider, you should contact the provider's office and arrange for the necessary records to be forwarded to 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.

9.2.3 Exhaustion of Process

You must exhaust the applicable levels of Appeal under this Appeal Procedure before you initiate any litigation or other legal proceeding related to your plan benefits. Benefits will be paid under the Plan only if the Grievance Committee, or if applicable, the Independent Review Organization (IRO) determines in its discretion that you are entitled to them. Any such determination shall be final and binding.

9.2.4 External Review

If you are not satisfied with the internal Grievance or Appeal decision and your Appeal involves (a) medical judgment (as determined by the external reviewer) or (b) rescission of coverage (whether or not the rescission has an effect on any particular benefit at that time), you may request an external review by an IRO. The IRO is an independent review organization that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct external reviews. The IRO is entirely independent of the Plan and Providence Health Plan, and performs external reviews under a contract with Providence Health Plan.

For purposes of this Plan, SAIF as Plan Sponsor has delegated its external review duties and obligations, as described in this section 9.2.4, to Providence Health Plan.

Time Frame for Requesting External Review

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. Your request for external review must be made in writing to Providence Health Plan within 4 months from the date you received the internal Grievance or Appeal decision or that internal decision will become final. If you agree, Providence Health Plan may waive the requirement that you exhaust the internal review process before beginning the External Review process.

But for urgent care claims, you may request an expedited external review immediately upon receipt of an Adverse Benefit Determination or a final Adverse Benefit Determination before an internal Appeal decision is made. An urgent care claim is one which involves a medical condition for which the time frame for completion of an expedited internal appeal or a standard external review would: (1) seriously jeopardize your life or health or your ability to regain maximum function; or (2) if the final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service from which you received emergency services but have not yet been discharged from the facility.

Preliminary Review

Within five (5) business days after receipt of your request for external review, Providence Health Plan will complete a preliminary review to determine if your claim is eligible for external review based on the following criteria:

- Whether you were covered under the Plan at the time the health care item or service was requested or provided;
- Whether the final Adverse Benefit Determination was due to you not being eligible for coverage under the terms of the Plan;
- Whether you have exhausted the Plan's internal Appeal process (unless waived); and
- Whether you have provided all information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, we will notify you in writing if the request is not eligible for external review or if it is incomplete. If the request is not eligible for review, the notice will explain the reasons for our ineligibility decision and provide you with contact information for the Employee Benefits Security Administration. If the request is incomplete, the notice will explain what additional information is needed. You will then have the remainder of the 4-month period or 48 hours from the notice (whichever is longer) to perfect your request by submitting the requested information to Providence Health Plan.

For expedited requests, Providence Health Plan will complete the preliminary review and notify you of its review eligibility decision immediately.

Assignment to IRO

If your request meets the preliminary review criteria above, the claim will be assigned to an IRO immediately. Providence Health Plan will forward to the IRO all documentation considered in the denial of your claim or rescission of coverage within five (5) business days. For expedited requests, Providence will forward all relevant information to the IRO immediately in the most expeditious manner possible.

The IRO will then promptly notify you and Providence Health Plan of the eligibility and acceptance or rejection of your claim for external review, based upon whether the Plan's denial involves (a) medical judgment or (b) rescission of coverage.

Submitting Additional Information to IRO

You may submit additional information, in writing, that you wish to be considered by the IRO within 10 business days after receipt of the IRO's notice of eligibility and acceptance of your case for review.

The IRO will forward any additional information you submit to Providence Health Plan for consideration. Upon receipt, if Providence Health Plan determines upon reconsideration to reverse its denial decision, you and the IRO will be provided with notice of such reversal within one (1) business day of the decision. Upon such notice, the IRO will terminate the external review.

Scope of IRO Review

The IRO will review and consider all information that is timely received from you and Providence Health Plan. In reaching a decision, the IRO will review the claim anew on a *de novo* basis and is not bound by any decisions or conclusions reached during the Plan's internal claim or appeal process.

External Review Decision

The IRO must notify you of its decision in writing within 45 days after the IRO receives the request for external review. For expedited requests, the IRO will notify you of its decision as expeditiously as your medical circumstances require, but in no event more than 72 hours after the IRO receives the request for expedited external review. If the decision for an expedited review was delivered to you orally, the IRO will send written confirmation of that oral decision to you within 48 hours thereafter.

The Plan and Providence Health Plan agree to be bound by and to comply with the IRO decision when the decision involves (a) medical judgment or (b) rescission of coverage, as described in this section above, except to the extent that other remedies may be available under state or federal law to either the Plan or the Member, or to the extent the Plan voluntarily makes payment on the claim or otherwise provides benefits at any time (including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits).

All costs for the handling of external review cases are paid by the Plan, and Providence Health Plan administers these provisions in accordance with federal laws and regulations.

9.2.5 How to Submit Grievances or Appeals and Request Appeal Documents

You may contact Providence 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 or requests for External Review 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 or requests for External Review 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

10. TERMINATION OF MEMBER COVERAGE

10.1 TERMINATION EVENTS

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

1. The date this Plan terminates;
2. The last day of the coverage period in which a Subscriber terminates employment with the SAIF Corporation, as stated in the Summary Plan Description;
3. The last day of the coverage period in which a Subscriber qualifies as a Subscriber, as stated in the summary Plan Description;
4. The Subscriber retires and does not elect coverage under this Plan as a Non-Medicare Eligible Retiree within 60 days of separation;
5. The last day of the month in which the Subscriber makes a written request for termination of coverage to be effective for the Subscriber or Member;
6. For a Family Member, the date the Subscriber's coverage terminates;
7. For a Family Member, the last day of the month in which the individual no longer qualifies as an Eligible Family Dependent;
8. For any benefit, the date the benefit is deleted from this Plan;
9. For a Member, the date of disenrollment from this Plan as described in section 10.3;
10. For a Member, the date any fraudulent information is provided; or
11. For a Member, the date we discover any breach of contractual duties, conditions or warranties, as determined by us.
12. For a Subscriber that is a Non-Medicare Eligible Retiree enrolled in a SAIF Retiree medical plan, the last day of the month in which the Retiree becomes eligible for Medicare.

You are responsible for advising the SAIF Corporation Human Resources Division 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 SAIF Corporation.

10.2 TERMINATION AND RECISSION OF COVERAGE DUE TO FRAUD OR ABUSE

Coverage under this Plan, either for you or for your covered dependent(s) may be rescinded (deemed from the beginning as never effective) or terminated in case of a fraud or intentional misrepresentation of material fact by you or by your covered dependent in obtaining, or attempting to obtain, benefits under this Plan.

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

10.3 NON-LIABILITY AFTER TERMINATION

Upon termination of this Plan, SAIF Corporation shall have no further liability beyond the effective Termination Date unless the Member continues, without lapse of membership, under another SAIF Corporation plan.

10.4 DISENROLLMENT FROM THIS PLAN

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

1. You have filed a false claim with the Plan;
2. You willfully fail to provide information or documentation required to be provided under this Plan or knowingly provide incorrect or incomplete information;
3. You have committed an act of physical or verbal abuse that poses a threat to providers, to other Members, or to SAIF Corporation or Providence Health Plan employees; or
4. You have allowed a non-Member to use your Member ID Card to obtain Services.

10.5 PROOF OF PRIOR COVERAGE

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

10.6 RIGHT TO TERMINATE OR AMEND PLAN

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

11. CONTINUATION OF GROUP MEDICAL BENEFITS

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

11.1 COBRA CONTINUATION COVERAGE

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

11.1.1 Subscriber's Continuation Coverage

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

11.1.2 Spouse's or Domestic Partner's Continuation Coverage

A Spouse or Domestic Partner who is covered under this Plan has the right to elect continuation coverage under COBRA if coverage is lost for any of the following qualifying events:

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

11.1.3 Dependent's Continuation Coverage

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

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

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

11.1.4 Notice Requirements

A Family Member's coverage ends on the last day of the month in which a divorce, legal separation or termination of domestic partnership occurs or a child loses dependent status under this Plan. **Under COBRA, you or your Family Member has the responsibility to notify SAIF Corporation if one of these events occurs.** Written notice must be given no later than 60 days after the loss of coverage has occurred, or the qualifying event, whichever is later. Oral notice is not binding until confirmed in writing. If notice is not timely given, continuation coverage will not be available.

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

11.1.5 Type of COBRA Continuation Coverage

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

11.1.6 COBRA Election Rights

A Subscriber or his or her Spouse or Domestic Partner may elect continuation coverage for all covered Family Members. In addition, each Family Member that is a qualified beneficiary has an independent right to elect COBRA. Thus, a Family Member may elect continuation coverage even if the Subscriber does not.

11.1.7 COBRA Premiums

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

11.1.8 Length of COBRA Continuation Coverage

18-Month Continuation Period

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

29-Month Continuation Period

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

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

The premium for COBRA continuation coverage may increase after the 18th month to 150% of the otherwise applicable amount.

If the SSA makes a final determination of non-disability, the qualified beneficiary must notify the COBRA Administrator within 30 days.

36-Month Continuation Period

If a Spouse, Domestic Partner or Eligible Family Dependent loses coverage because of any of the following reasons, COBRA provides for up to 36 months of continuation of coverage:

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

11.1.9 Extension of Continuation Period

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

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

11.1.10 Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (TAA). TAA allows workers displaced by the impact of foreign trade, and individuals age 55 or older who are receiving pension benefits paid by the Pension Benefit Guaranty Corporation (PBGC), to elect COBRA coverage during the 60-day period that begins on the first day of the month in which the individual first becomes eligible for TAA benefits. Eligible individuals can either take a tax credit or get advance payment of sixty-five percent of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer contact Center toll-free at 866-628-4282. TTD/TTY caller may call toll-free at 866-626-4282. More information about the Trade Act is also available at <http://www.doleta.gov/tradeact/>.

11.1.11 When COBRA Continuation Coverage Ends

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

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

12. MEMBER RIGHTS AND RESPONSIBILITIES

12.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES

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

Members have the right to:

- Be cared for by people who respect your privacy and dignity.
- Be informed about Providence Health Plan, our providers, and the benefits and Services you have available to you as a Member.
- Receive information that helps you select a Qualified Practitioner whom you trust and with whom you feel comfortable.
- A candid discussion of appropriate or Medically Necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Receive information and clinical guidelines from your health care provider or your health plan that will enable you to make thoughtful decisions about your health care.
- Actively participate in decisions that relate to your health and your medical care through discussions with your health care provider or through written advance directives.
- Have access to medical Services that are appropriate for your needs.
- Express a concern 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 the 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 this Plan. We will have no liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact us. We will assist you in understanding and complying with the terms of the Plan.
- Talk openly with your physician or provider 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.

12.2 INFORMATION FOR NON-ERISA MEMBERS (PARTICIPANTS)

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

As a participant in your Employer’s Group Plan, you are entitled to certain rights and protections:

- 1. Receive from us information maintained about you by your Employer’s Group Plan**
 - You are entitled to access to recorded personal information under the Health Information and Affordable Care Act of 1996, provided you request it in writing and reasonably describe the information.
 - You may obtain copies, subject to paying a reasonable copying charge.
 - You are entitled to know to whom we may have disclosed any such information.
 - You are entitled to correct any errors in the information.
- 2. Continue group health coverage**
 - Continue health care coverage for yourself, spouse or dependents under the circumstances described in section 11.1.

3. Enforce your rights

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

As more fully described in section 9, we offer a Grievance process that attempts to resolve the concerns Members may have about claims decisions. No civil action may be brought to recover benefits from this Plan until receipt of a final decision under the Member Grievance and Appeal process specified in section 9.2. If the Member elects to seek external review under section 9.2.5, SAIF will be bound by the IRO decision. No civil action may be brought later than three years after the date of the last decision rendered under the Member Grievance and Appeal process specified in section 9.2.

Member's sole right of appeal from a final Grievance determination, other than a determination referred for binding determination by an independent review organization, shall be to an Oregon state court, either in the Member's county of residence or such other county as mutually agreed upon between the Member and the Plan. In the alternative, Member may request that the Plan agree to submit the dispute to binding arbitration before a single arbitrator appointed by the United States Arbitration & Mediation Service (USA&M) under Oregon law in the Member's county (unless otherwise mutually agreed) in accordance with USA&M's Rules for Arbitration. If arbitration is mutually agreed upon, the arbitrator's decision shall be final and legally binding and judgment may be entered thereon. Irrespective of whether the Grievance is appealed to a court, 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 Plan.

13. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

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

13.1 DEFINITIONS

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

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

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

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

A “Qualified Medical Child Support Order” or “QMCSO” means an Order:

- Which creates or recognizes the existence of an Alternate Recipient’s right to receive, or assigns to an Alternate Recipient the right to receive, benefits for which an employee or beneficiary is eligible under the Plan; and
- With respect to which SAIF Corporation has determined satisfies the QMCSO standards set forth below.

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

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

13.2 NOTICE UPON RECEIPT OF ORDER

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

13.3 NOTICE OF DETERMINATION

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

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

(a) Clearly specifies:

1. The name and last known mailing address (if any) of the employee and of each Alternate Recipient covered by the Order (or the name and mailing address of a State or agency official acting on behalf of the Alternate Recipient);
2. Either a reasonable description of the type of coverage to be provided under the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and
3. The period to which the Order applies.

(b) Does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent that the Order pertains to the enforcement of a state law relating to a medical child support.

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

13.4 ENROLLMENT OF ALTERNATE RECIPIENT

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

13.5 COST OF COVERAGE

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

13.6 REIMBURSEMENT OF PLAN EXPENSES

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

13.7 STATUS OF ALTERNATE RECIPIENT

An Alternate Recipient under a QMCSO generally will be considered a beneficiary of the Employee under the Plan to which the Order pertains. Notwithstanding the foregoing, such Alternate Recipient will be considered a Member of the Plan for purposes of the reporting and disclosure requirements of ERISA, including in regard to the right to independently receive a Summary Plan Description with respect to the Plan.

13.8 TREATMENT OF NATIONAL MEDICAL SUPPORT NOTICE

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

SAIF Corporation, upon determining that the National Notice is a QMCSO, shall within forty (40) business days after the date of the National Notice notify the State agency issuing the National Notice of the following:

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

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

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

14. GENERAL PROVISIONS

14.1 CONFLICTS OF PROVISIONS

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

14.2 CONTROLLING STATE LAW

To the extent not preempted by federal laws, the laws of the State of Oregon shall apply and shall be the controlling state law in all matters relating to the Plan.

14.3 DUPLICATING PROVISIONS

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

14.4 FAILURE TO PROVIDE INFORMATION

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

14.5 GENDER AND NUMBER

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

14.6 HEADINGS

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

14.7 LEGAL ACTION

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

14.8 LIMITATIONS ON PROVISIONS

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

14.9 MEMBER RESPONSIBILITY

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

14.10 MEMBERSHIP ID CARD

The membership 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 Plan.

14.11 NO GUARANTEE OF EMPLOYMENT

Neither the maintenance of the Plan nor any part thereof shall be construed as giving any employee covered hereunder any right to remain in the employ of SAIF Corporation. No shareholder, director, officer, or employee of SAIF Corporation in any way guarantees to any Member or beneficiary the payment of any benefit or amount which may become due in accordance with the terms of the Plan.

14.12 NO RECOURSE FOR ACTS OF PROVIDERS

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

14.13 NON-TRANSFERABILITY OF BENEFITS

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

14.14 NON-WAIVER

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

14.15 NOTICE

Any notice required of SAIF Corporation or Providence Health Plan under this Plan shall be deemed to be sufficient if mailed to the Member at the address appearing on the records of Providence Health Plan. Any notice required of you shall be deemed sufficient if mailed to the principal office of Providence Health Plan at P.O. Box 4447 Portland, OR 97208.

14.16 NOTICE REQUIRED FOR REIMBURSEMENT AND PAYMENT OF CLAIM

Plan payments for most Services are made directly to the providers of Services. Except as otherwise specifically provided in this Plan, if you are billed directly by an Out-of-Network Provider and you pay for benefits which are covered by this Plan, reimbursement from the Plan will be made only upon your written notice to Providence Health Plan of the payment. Payment will be made to the Member, subject to written notice of claim, or, if deceased, to the Member's estate, unless payment to other parties is authorized in writing by you. See section 8.1.1 regarding timely submission of claims.

14.17 PAYMENT OF BENEFITS TO PERSONS UNDER LEGAL DISABILITY

Whenever any person entitled to payments under the Plan is determined to be a minor or under other legal disability or otherwise incapacitated in any way so as to be unable to manage such person's financial affairs, or otherwise incapable of giving a valid receipt and discharge for any payment, the following provision shall apply. Providence Health Plan, in their discretion, may direct that all or any portion of such payments be made (i) to such person, (ii) to such person's legal guardian or conservator, or (iii) to such person's spouse or to any other person, in any manner considered advisable, to be expended for the person's benefit. Providence Health Plan's decision will, in each case, be final and binding upon all persons. Any payment made pursuant to the power herein conferred shall operate as a complete discharge of the obligations under the Plan in respect thereof by SAIF Corporation and Providence Health Plan.

14.18 PHYSICAL EXAMINATION AND AUTOPSY

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

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

14.19 PROFESSIONAL REVIEW AND RIGHT TO EXAMINE RECORDS

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

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

14.20 REQUIRED INFORMATION TO BE FURNISHED

Each Member must furnish to Providence Health Plan such information as they consider necessary or desirable for purposes of administering the Plan, and the provisions of the Plan respecting any payments hereunder are conditional upon the prompt submission by the Member of such true, full and complete information as may be requested.

14.21 RIGHT OF RECOVERY

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

14.22 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.

14.23 STATE MEDICAID BENEFITS RIGHTS

Notwithstanding any provision of the Plan to the contrary:

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

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

14.24 SUGGESTIONS

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

14.25 VETERANS' RIGHTS

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

- (a) The Subscriber and/or their Eligible Family Dependent who takes unpaid military leave, or who separates from the employment of SAIF Corporation to perform

services in the armed forces or another uniformed service, can elect continued coverage under the Plan (including coverage for the Eligible Family Dependents) on a self-pay basis. The applicable Contribution for such coverage, and the Contribution payment procedures, shall be as generally prescribed for COBRA continuation coverage in section 11. Effective for elections made on or after December 10, 2004, the period for such continuation coverage shall extend until the earlier of:

1. The end of the 24 month period beginning on the date on which the Subscriber and/or their Eligible Family Dependent 's absence for the purpose of performing military service begins; or
2. The date the Subscriber and/or their Eligible Family Dependent fails to timely return to employment or reapply for a position with SAIF Corporation upon the completion of such military service.

14.26 WORKERS' COMPENSATION INSURANCE

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

15. PLAN ADMINISTRATION

15.1 TYPE OF ADMINISTRATION

The Plan is a self-funded group health plan sponsored by the Employer with administrative services provided by Providence Health Plan. The funding for the benefits is derived from the funds of the Employer and contributions made by Participants. The Plan is not insured.

This Summary Plan Description constitutes the written instrument under which the Plan is maintained and this document replaces all previous Summary Plan Descriptions. The rights of any person whose employment has terminated, and the rights of such person's covered dependents, will be determined pursuant to the terms of the Plan as in effect on the date such employment terminated, except as may otherwise be specifically provided under the Plan.

15.2 PLAN INFORMATION

Plan Name: SAIF Corporation Health Benefits Plan
Employer ID No.: 93-6001769

15.3 PLAN DATES

The effective date of the Plan is January 1, 2024 and the Plan Year ends on December 31, 2024.

15.4 PLAN SPONSOR INFORMATION

SAIF Corporation
400 High Street SE
P.O. Box 988
Salem, OR 97308-0988

If there are any questions regarding this Plan or document, Members should contact:

SAIF Corporation
Human Resources Division
P.O. Box 988
400 High Street SE
Salem, OR 97308-0988
503-373-8040 or 1-800-285-8525

15.5 ADMINISTRATIVE SERVICES PROVIDED BY

Providence Health Plan
P.O. Box 4447
Portland, OR 97208-4447
800-878-4445

15.6 AGENT FOR SERVICE OF LEGAL PROCESS

Shannon Rickard
VP of Legal & Strategic Services
SAIF Corporation
P.O. Box 988
400 High Street SE
Salem, OR 97308-0988

15.7 ADMINISTRATIVE SERVICES

The Employer, as Plan Administrator as defined in ERISA, shall be responsible for all fiduciary functions under the Plan except insofar as any such authority or responsibility is assigned by or pursuant to the Plan to another named fiduciary, or is delegated to another fiduciary by the Employer. The Employer has the discretionary authority to determine eligibility for benefits under the Plan and to interpret the terms of the Plan, unless it has delegated that authority as permitted by the Plan. In the event of such delegation, Providence Health Plan's determinations on the meaning of Plan terms may not be overturned unless found by a court to have been arbitrary and capricious. The allocation of administrative duties and the delegation of discretionary authority for the Plan is specified in the Administrative Services Agreement that has been executed by the Employer and Providence Health Plan.

15.7.1 Complete Allocation of Fiduciary Responsibilities

This section is intended to allocate to each named fiduciary the individual responsibility for the prudent execution of the functions assigned to each. The performance of such responsibilities will be deemed a several and not a joint assignment. None of such responsibilities nor any other responsibility is intended to be shared by two or more of them unless such sharing will be provided by a specific provision of the Plan. Whenever one named fiduciary is required by the Plan to follow the directions of another, the two will not be deemed to have been assigned a shared responsibility, but the responsibility of the one giving the direction will be deemed to be its sole responsibility, and the responsibility of the one receiving such direction will be to follow it insofar as such direction is on its face proper under the Plan and applicable law.

15.8 ENGAGEMENT OF ADVISORS

The Employer may employ on behalf of the Plan one or more persons to render advice with regard to any responsibility it may have under the Plan. Toward that end, the Employer may appoint, employ and consult with legal counsel, actuaries, accountants, investment consultants, physicians or other advisors (who may be counsel, actuaries, accountants, consultants, physicians or other advisors for the Employer) and may also from time to time utilize the services of employees and agents of the Employer in the discharge of their respective responsibilities.

15.9 INDEMNIFICATION

The Employer will indemnify its employees for any liability or expenses, including attorneys' fees, incurred in the defense of any threatened or pending action, suit or proceeding by reason of their status as a fiduciary with respect to the Plan, to the full extent permitted by law.

15.10 AMENDMENT OR TERMINATION OF PLAN

15.10.1 Right to Amend or Terminate

The Employer reserves the right at any time, and from time to time, to amend or terminate, in whole or in part, any of the provisions of the Plan, or any document forming part of the Plan.

15.10.2 Manner of Action

Any amendment or termination of the Plan or any part of the Plan shall be made by an instrument in writing reflecting that such change has been authorized by the Employer. Any such amendment or termination shall be effective as of the date specified in said instrument, or, if no date is so specified, as of the date of execution or adoption of said instrument. An amendment may be effected by establishment, modification, or termination of the Plan by appropriate action of the Employer. Any such amendment or termination may take effect retroactively or otherwise. An instrument regarding the establishment, modification or termination of the Plan which is executed by the Vice President of Human Resources of the Employer shall be conclusive evidence of the adoption and effectiveness of the instrument.

15.10.3 Effect on Benefits

Claims incurred before the effective date of a Plan change or termination will not be affected. Claims incurred after Plan changes will be covered according to the provisions in effect at the time the claim is incurred. Claims incurred after the Plan is terminated will not be covered. You will not be vested in any Plan benefits or have any further rights, subject to applicable law.

15.11 PROTECTED HEALTH INFORMATION

15.11.1 Disclosure

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

- (a) The Employer may use and disclose the PHI it receives only for the following purposes:
 1. Administration of the Plan; and
 2. Any use or disclosure as required by law.
- (b) The Employer shall ensure that any agent or subcontractor to whom it discloses such PHI shall agree to the same restrictions and conditions that apply to the Employer with respect to such information.
- (c) The Employer shall not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.
- (d) The Employer shall report to Providence Health Plan any use or disclosure of PHI that is inconsistent with the provisions of this section of which the Employer becomes aware.

- (e) The Employer shall make PHI available to Participants in accordance with the privacy regulations of HIPAA.
- (f) The Employer shall allow Participants to amend their PHI in accordance with the privacy regulations of HIPAA.
- (g) The Employer shall provide Participants with an accounting of its disclosure of their PHI in accordance with the privacy regulations of HIPAA.
- (h) The Employer shall make its internal practices, books and records relating to the use and disclosure of PHI received from Providence Health Plan available to the Secretary of the Department of Health and Human Services in accordance with the privacy regulations of HIPAA.
- (i) The Employer shall, if feasible, return or destroy all PHI received from Providence Health Plan and retain no copies of such information when no longer needed for the purpose for which such information was received except that, if such return or destruction is not feasible, the Employer shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- (j) The Employer shall provide for adequate separation between the Employer and Providence Health Plan with regard to the use and disclosure of PHI. For that purpose, access to PHI shall be limited to the following employees or classes of employees of the Employer:
 1. Directors of Human Resources;
 2. Human Resources Managers;
 3. Benefit Administrators;
 4. Benefit Specialists; and
 5. Internal Auditors, when performing Health Plan Audits.

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

15.11.2 Security

In accordance with the security standards of the Health Insurance Portability and Accountability Act (HIPAA), the Employer shall:

- (a) Implement administrative, physical, and technical safeguards that protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
- (b) Ensure that the separation of access to PHI that is specified in section 15.11.1(j) above is supported by appropriate security measures;
- (c) Ensure that any agent or subcontractor to whom the Employer provides PHI agrees to implement appropriate security measures to protect such information; and
- (d) Report to the Plan any security incident regarding PHI of which the Employer becomes aware.

16. DEFINITIONS

The following are definitions of important capitalized terms used in this Summary Plan Description.

Adverse Benefit Determination

See section 9.

Alternative Care Provider

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

Ambulatory Surgery Center

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

Annual

Annual means once per Calendar Year.

Appeal

See section 9.

Approved Clinical Trial

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

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

Authorized Representative

See section 9.

Benefit Summary

Benefit Summary means the document with that title which is part of your Plan and which summarizes the benefit provisions under your Plan.

Calendar Year

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

Cochlear Implant

See section 5.8.15.

Coinsurance

Coinsurance means the dollar amount that you are responsible to pay to a health care provider, after your claim has been processed by Providence Health Plan, for a Covered Service that is a percentage of the Usual, Customary and Reasonable charges for the Covered Service, as shown in the medical Benefit Summary.

Confinement

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

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

Contribution

Contribution means the monetary amount that an Employee is required to contribute as a condition to coverage under the Plan. Specific Contribution amounts are available from your Human Resources office.

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:

1. Listed as a benefit in the Benefit Summary and in sections 5 and 6;
2. Medically Necessary;
3. Not listed as an exclusion in sections 5, 6 or 7; and
4. Provided to you while you are a Member and eligible for the Service under this Plan.

Creditable Coverage

Creditable Coverage means prior health care coverage as defined in 42 U.S.C. § 300gg and includes any coverage remaining in force at the time a Member obtains new coverage.

Creditable Coverage includes any group health care coverage (including the Federal Employees Health Benefits Plan and the Peace Corps), individual health care coverage, Medicare, Medicaid, TRICARE, SCHIP, Indian Health Service or tribal organization coverage, state high-risk pool coverage, or a domestic or foreign public health plan.

Custodial Care

Custodial Care means Services that:

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

Such Services will still be considered Custodial Care even if:

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

Deductible

See section 4.10.1.

Dependent

Dependent means a person who is supported by the Subscriber or the Subscriber's Spouse. See also Eligible Family Dependent.

Diagnostic Breast Examination

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

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

Domestic Partner

A Domestic Partner means either of the following:

1. An Oregon Registered Domestic Partner is a person who:
 - Is at least 18 years of age;
 - Has entered into a Domestic Partnership; and
 - Has legally registered a Declaration of Domestic Partnership and obtained a Certificate of Registered Domestic Partnership in accordance with Oregon state law.
2. A Domestic Partner who is not an Oregon Registered Domestic Partner is a person at least 18 years of age who:
 - Shares a close personal relationship with a subscriber such that each is responsible for each other's welfare;
 - Is the subscriber's sole domestic partner;
 - Is not married to any person and has not had another domestic partner within the prior six months;
 - Is not related by blood to the subscriber as a first cousin or nearer;
 - Shares with the subscriber the same regular and permanent residence, with the current intention of doing so indefinitely;
 - Is jointly financially responsible with the subscriber for basic living expenses such as food and shelter;

- Was mentally competent to consent to contract when the domestic partnership began; and
- Has provided the required employer documentation establishing that a domestic partnership exists.

Note: All provisions of the Plan that apply to a Spouse shall apply to a Domestic Partner.

Durable Medical Equipment (DME)

Durable Medical Equipment means equipment that must:

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

E-mail Visit

E-mail Visit (electronic provider communications) means a consultation through e-mail with an In-Network Provider that is, in the judgment of the In-Network Provider, Medically Necessary and appropriate and involves a significant amount of the In-Network Provider's time. An E-mail Visit must relate to the treatment of a covered illness or injury (see also section 5.1.3).

Effective Date of Coverage

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

Eligible Employee

Eligible Employee means an employee of the Employer who meets all of the following eligibility criteria and the enrollment requirements specified in section 3.1.

1. Employment Category/Class:
 - a. Permanent. (On-call, short-term temporary, substitute, and seasonal employees are not eligible.)
 - b. Long-Term Temporary. (Employee-only Class.)
2. Work Hours:
 - a. Permanent: Regularly scheduled for at least 20 hours per week.
 - b. Long-Term Temporary: Regularly scheduled to work 87 hours per month.
3. Eligibility Waiting Period: See Effective Date of Coverage.
4. Effective Date of Coverage: Date of hire.
5. Leave of Absence Status: An otherwise Eligible Employee on an Employer-approved Leave of Absence shall remain eligible during the first 3 months of leave of absence. Absences extending beyond this period are subject to the COBRA and/or Portability provisions of this Summary Plan Description. See section 3.6.
6. Layoff/Rehire: If the Eligible Employee is rehired within 9 months, the Eligibility Waiting Period is waived.
7. Retirement Status: Non-Medicare Eligible Employees who retire from SAIF Corporation and apply for Oregon Public Employee Retiree System Benefits within 60 days from date of separation are eligible to enroll in a SAIF Retiree medical plan.
8. Active Working Retirees who return to SAIF employment for at least 20 hours per week on a temporary assignment lasting longer than 90 days.

Eligible Family Dependent

Eligible Family Dependent means:

1. A legally married spouse, registered domestic partner, or un-registered domestic partner. Unregistered domestic partners must meet the definition of a domestic partner based on criteria established by Providence Health Plan.
2. Dependent children to age 26 who are natural children, step-children, children of a domestic partner. Children under legal guardianship to age 18. A child placed for pending adoption, and a legally adopted child.
3. Dependent children who are incapable of self-sustaining employment because of a physical or mental handicap. Such children may be eligible to remain covered even though they are over 26. To be eligible, the handicap must have occurred before the child's 26th birthday (additional affidavit will be required).
4. A Child by Affidavit includes but not limited to a foster child, grandchild, child placed for adoption, or court ordered placement of a child who lives in the household of the eligible employee, and is the eligible employee's IRS dependent. The employee must provide court ordered documentation of guardianship and the notarized Affidavit of Child Dependency upon enrollment. Coverage ends the last day of the month in which the court ordered guardianship ends or age 26. An eligible employee may not add a child by affidavit age 26 or older to coverage unless they can provide court ordered documentation for responsibility of the child beyond the age of 26.
5. The biological child of an eligible dependent child of an eligible employee, spouse, or domestic partner (a grandchild by affidavit) and meets all the following criteria:
 - a. The child's parent will not be older than age 26 on the last day of the plan year, is unmarried and without a domestic partner. Both the child's parent and the child live in the household of the eligible employee, and both the child and grandchild are the eligible employee's IRS dependent. The child's parent has health coverage through the eligible employee. The grandchild is automatically covered as an eligible dependent for the first 31 days from birth without documentation and Affidavit in place. The Affidavit and any appropriate documentation must be on file the first of the month following the event date in order to meet eligibility requirements and continue coverage under the Plan rules. An eligible employee may not add a grandchild age 26 or older to their coverage unless they can provide court ordered documentation for responsibility of the child beyond the age of 26.

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

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

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

Proof of incapacity must be provided to the Plan upon enrollment. For Eligible Family Dependents who become incapacitated while covered under this Plan, proof of incapacity must be provided within 60 days of reaching the Dependent child limiting age as stated in this Plan. 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 the Plan, the individual's coverage will not continue beyond the last date of eligibility.

Eligibility Waiting Period

Eligibility Waiting Period means the period of employment, as specified in the Eligible Employee definition, that an employee must complete before coverage will begin under this Plan. If an employee enrolls on a special enrollment date, any period before such special enrollment is not an Eligibility Waiting Period.

Emergency Medical Condition

See section 5.5.1.

Emergency Medical Screening Exams

See section 5.5.1.

Emergency Services

See section 5.5.1.

Employer

Employer means SAIF Corporation, an Oregon independent public corporation, and the Plan Sponsor.

Endorsement

Endorsement means a document that amends and is part of this Plan.

ERISA

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Exclusion

Exclusion means an item or service that is not a Covered Service under the Plan.

Family Member

Family Member means a Dependent who is properly enrolled in and entitled to Covered Services under this Plan.

Gender Dysphoria

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

Gene and Adoptive Cellular Therapy

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

Global Fee

See section 6.1.2.

Grievance

See section 9.

Health Benefit Plan

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

Hearing Aid

See section 5.8.15.

Hearing Assistance Technology

See section 5.8.15.

HIPAA

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

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 is Medicare approved as a Home Health Agency.

Hospital

Hospital means an institution which:

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

Hospital does NOT include an institution that is principally a rest home, nursing home, 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.

In-Network

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

In-Network Provider

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

Independent Freestanding Emergency Department

Independent Freestanding Emergency Department means a health care facility that provides Emergency Services and is geographically separate and distinct and licensed separately from a Hospital under applicable state law. See section 4.5.1.

Ineligible Person

Ineligible Person means any person who does not qualify as a Member under this Plan.

Investigational

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

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

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

Late Enrollee

Late Enrollee means a person eligible to enroll under a Special Enrollment Period, as described in section 3.4.

Medically Necessary

Medically Necessary means Covered Services that are in the reasonable opinion of Providence Health Plan, consistent with the written criteria regarding medically indicated Covered Services that are maintained by Providence Health Plan. The criteria are based on the following principles:

1. Covered Services are determined to be Medically Necessary if they are health care services or products that a Qualified Practitioner, exercising prudent clinical judgment, would provide to a Member for the purpose of evaluating, diagnosing, preventing, or treating illness (including mental illness), injury, disease or its symptoms, and that are:
 - a. In accordance with generally accepted standards of medical practice;
 - i. Generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Qualified Practitioner specialty society recommendations, the views of Qualified Practitioners practicing in relevant clinical areas, and any other relevant factors;

- b. Clinically appropriate, in terms of type, frequency, extent, site and duration; and considered effective for the Member's medical condition;
- c. Not primarily for the convenience of the Member or Qualified Practitioner; and
- d. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis, prevention or treatment of that Member's illness, injury or disease.

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

Member

Member means a Subscriber or Eligible Family Dependent, who is properly enrolled in and entitled to Services under this Plan.

Mental Health

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

Non-Medicare Eligible Retiree

Non-Medicare Eligible Retiree means a Subscriber who retires from employment with SAIF Corporation and applies for Oregon Public Employee Retiree System Benefits within 60 days from date of separation who is eligible to enroll in this Plan.

Open Enrollment Period

Open Enrollment Period means a period during each Plan Year, as established by SAIF Corporation during which Eligible Employees are given the opportunity to enroll themselves and their Dependents under the Plan for the upcoming Plan Year, subject to the terms and provisions as found in this Summary Plan Description.

Out-of-Network

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

Out-of-Network Provider

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

Out-of-Pocket Maximum

See section 4.10.2.

Outpatient Surgical Facility

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

Participating Pharmacy

See Section 5.9.

Primary Care Provider

Primary Care Provider means a Qualified Practitioner specializing in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; 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 also choose a provider 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 Provider Directory online or call Customer Service.)

Plan

Plan means the SAIF Corporation group health plan, as set forth in this document, the Summary Plan Description, and includes the provisions of the Benefit Summaries and any Endorsements, amendments and addendums that accompany this document.

Plan Administrator

Plan Administrator means the "Administrator" or "Plan Administrator" as those terms are defined under ERISA and shall refer to the current or succeeding person, committee, partnership, or other entity designated as such by the terms of the instrument under which the Plan is operated, or by law. Regardless of the terms of the instrument under which the Plan is operated, Providence Health Plan is not the Plan Administrator.

Plan Year

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

Portability Plans

Portability Plan means an individual plan of continuation coverage, as specified in the Oregon Insurance Code, which is available to Oregon residents who lose coverage under a group Health Benefit Plan.

Premium

Premium means the monetary amount that a Member is required to pay as a condition to continue plan coverage under the COBRA provisions specified in section 11. Specific COBRA premium amounts are available from your Human Resources office.

Prior Authorization

Prior Authorization or Prior Authorized means a request to Providence Health Plan or their authorizing agent 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 Services requested. We may also require that a Member receive further evaluation from a Qualified Practitioner of our choosing. Prior Authorization is subject to the terms and provisions of this Summary Plan Description. More information about Prior Authorizations are shown in section 4.4.

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

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

Providence ExpressCare Virtual Visits

Providence ExpressCare Virtual Visits can be utilized for common conditions; such as sore throat, cough, or fever, etc. using Providence's web-based platform through a tablet, smartphone, or computer for same day appointments. Virtual Visits are with In-Network Providers who are contracted with Providence Health Plan to provide Providence ExpressCare Virtual. Benefits will apply, as shown in your Benefit Summary. See section 5.1.2 for more details.

Providence Health Plan

Providence Health Plan means the nonprofit corporation authorized as a health care service contractor in the states of Oregon and Washington that serves as the claims administrator with respect to this Plan.

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 a functional impairment.

Retail Health Clinic

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

SAIF Corporation

SAIF Corporation means the entity that is the Sponsor of this Plan.

SAIF Corporation Health Benefits Plan

SAIF Corporation Health Benefits Plan means this Summary Plan Description and includes the provisions of the Benefit Summaries and any Endorsements, amendments and addendums that accompany this document.

Service

Service means a health care related procedure, surgery, consultation, advice, diagnosis, referrals, treatment, supply, medication, prescription drug, device or technology that is provided to a Member by an In-Network Provider or an Out-of-Network Provider.

Skilled Nursing Facility

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

Spouse

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

Subscriber

Subscriber means an employee, non-Medicare Eligible Retiree, or Active Working Retiree of SAIF Corporation who is eligible for benefits and is properly enrolled in accordance with the provisions of this Summary Plan Description.

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.

Summary Plan Description (SPD)

Summary Plan Description (SPD) means the description of the Plan as contained in this document, and includes the provisions of the Benefit Summaries, any Endorsements, amendments and addendums that accompany these documents, and those policies maintained by Providence Health Plan which clarify any of these documents.

Supplemental Breast Examination

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

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

Termination Date of Coverage

Termination Date of Coverage means the date upon which coverage under this Plan ends for a Member. No coverage under the Plan will be provided beyond the Termination Date of Coverage.

Urgent Care

See section 5.6.

Usual, Customary and Reasonable (UCR)

When a Service is provided by an In-Network Provider, UCR means charges based on the fee that Providence Health Plan has negotiated with In-Network Providers for that Service. UCR charges will never be less than Providence Health Plan's negotiated fees.

When a Service is provided by an Out-of-Network Provider, UCR charges will be based on the lesser of:

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

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), a physician assistant specializing in women's health, an advanced registered nurse practitioner specialist in women's health, a certified nurse midwife, or a licensed direct entry midwife practicing within the applicable lawful scope of practice.

17. NON-DISCRIMINATION STATEMENT

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

Providence Health Plan and Providence Health Assurance:

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

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

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

Providence Health Plan and Providence Health Assurance
Attn: Ronni Nichuals, Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158
Phone: 503-574-6236
Fax: 503-574-8757
Email: ronni.nichuals@providence.org

If you need help filing a grievance, call us at 503-574-7500 or 1-800-878-4445 (TTY: 711) for assistance.

You can also file a civil rights complaint with:

- The U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019 or, 800-537-7697 (TDD)

Complaint forms are available at <http://hhs.gov/ocr/office/file/index.html>.

Members of Oregon Plans may file a complaint with the Division of Financial Regulation at 1-888-877-4894 or visit <https://dfr.oregon.gov/Pages/index.aspx>.

Members of Washington Plans can file a complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900 or 360-586-0241 (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-898-8174 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-898-8174 (TTY: 711).

Russian: ВНИМАНИЕ: Если Вы говорите по-русски, то Вам доступны услуги бесплатной языковой поддержки. Звоните 1-800-898-8174 (телетайп: 711).

Vietnamese: CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-800-898-8174 (TTY: 711).

Traditional Chinese: 注意：如果您說中文，您可以免費獲得語言支援服務。請致電 1-800-898-8174 (TTY: 711)。

Kushite: XIYYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-898-8174 (TTY: 711).

Farsi:

توجه: اگر به زبان فارسی صحبت میکنید، تسهیلات زبانی ن به صورت رایگان به شما ارائه میشود. یا 1-800-898-8174 (TTY: 711) تماس بگیرید.

Ukrainian: УВАГА! Якщо Ви розмовляєте українською мовою, для Вас доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером 1-800-898-8174 (телетайп: 711).

Japanese: お知らせ：日本語での通話をご希望の場合、言語支援サービスを無料でご利用いただけます。1-800-898-8174 (TTY: 711)まで、お電話ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-898-8174 (TTY: 711) 번으로 전화해 주십시오.

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंले दनम्र भाषा सहायता सेवाहरू दनःशुल्क रूपमा उपलब्ध छन् । 1-800-898-8174 (TTY: 711) मा फोन गर्नुहोस् ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii gratuite de asistență lingvistică. Sunați 1-800-898-8174 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Rufnummer: 1-800-898-8174 (TTY: 711).

Hmong: LUS CEEB TOOM: Yog tias koj hais lus Hmoob, cov kev pab txhais lus, muaj kev pab dawb rau koj. Hu rau 1-800-898-8174 (TTY: 711).

Cambodian: កំណត់សម្គាល់: បើសិនជាអ្នកនិយាយភាសាខ្មែរ អាចម្តងបសវន្តយុទ្ធសាស្ត្រកកសាបោយមិនគិតថ្លៃពីបេកអ្នក។ សូមប្រើទូរស័ព្ទបលម 1-800-898-8174 (TTY: 711)។

Laotian: ເລື່ອງ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ຈະມີການຊ່ວຍເຫຼືອ ດ້ານພາສາ ໂດຍ ບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ 1-800-898-8174 (TTY: 711).

ADOPTION OF THE SUMMARY PLAN DESCRIPTION AS THE PLAN DOCUMENT

Adoption

On the date shown, below, the Plan Sponsor hereby adopts this Summary Plan Description and the Benefit Summaries, Endorsements and amendments which are incorporated by reference, as the Plan Document of the SAIF Corporation’s self-funded Employee Health Benefit Plan, SAIF Corporation Health Benefits Plan. This document replaces any and all prior statements of the Plan benefits which are described herein.

Purpose of the Plan

The purpose of the Plan is to provide certain benefits for SAIF Corporation’s Eligible Employees and Eligible Family Dependents. Those benefits are described in this Summary Plan Description.

Conformity with Law

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Acceptance of the Plan Document

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document and Summary Plan Description to be executed, effective as of January 1, 2024.

By: _____

Printed Name: _____

Title: _____

Company: _____

Date: _____

SAIF Contract Review: _____

If there are any questions regarding this document, members should contact:

SAIF Corporation
Human Resources Division
P.O. Box 988
400 High Street SE
Salem, OR 97308-0988
503-373-8040 or 800-285-8525

Administered by



Our Mission

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

Our Values

Compassion | Dignity | Justice | Excellence | Integrity

Questions? We’re here to help.

Speak to one of our Customer Service representatives at 503-574-7500 or 800-878-4445 (TTY: 711); or one of our Sales representatives at 503-574-6300 or 877-245-4077, 8 a.m. to 5 p.m. (Pacific Time) Monday through Friday.

ProvidenceHealthPlan.com

Providence Health & Services, a not-for-profit health system, is an equal opportunity organization in the provision of health care services and employment opportunities.