CLACKAMAS COUNTY

CHRISTINA L. MCMAHAN
DIRECTOR

JUVENILE DEPARTMENT
JUVENILE INTAKE AND ASSESSMENT CENTER
2121 KAEN ROAD | OREGON CITY, OR 97045

December 2, 2021

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of Amendment No. 1 to the Intergovernmental Agreement with Oregon Health Authority for Behavioral Rehabilitation Services (BRS) Reimbursements

Purpose/ Outcomes	Adds partial reimbursement for assessment and evaluation residential services contracted through Multnomah County Assessment and Evaluation Program to the existing Intergovernmental Agreement 167781.
Dollar Amount and Fiscal Impact	The estimated maximum annual net revenue to Clackamas County is $44,935.
Funding Source	Oregon Health Authority
Duration	Effective January 1, 2021 and terminates on December 31, 2022
Previous Board Action	The previous Intergovernmental Agreement (IGA) for this revenue was IGA number 144378. The original IGA was signed by Don Krupp, County Administrator, on 12/23/2013; Amendment 1 signed by Ellen Crawford, Juvenile Director, on 2/5/14; Amendment 2 signed by Don Krupp, County Administrator on 2/18/2015; Amendment 3 signed by Don Krupp, County Administrator, on 12/12/16; Amendment 4 was signed by Jim Bernard, Chair, on 5/23/19; Amendment 5 was signed by Jim Bernard, Chair, on 12/10/20; New IGA number 167781 was signed by Tootie Smith, Chair, on 2/25/21.
Strategic Plan Alignment	1. The purpose of the Assessment Program is to provide assessment services to youth referred to the Department so they can be matched with the appropriate level of monitoring and services. 2. Ensure safe, healthy, and secure communities.
Counsel Review	October 28, 2021 Counsel Initials: JM
Procurement Review	Did this purchase go through the Procurement Division: N/A This item is an IGA
Contact Person	Ed Jones, Administrative Services Manager – Juvenile Department 503-650-3169
Contract No.	167781-1

BACKGROUND:

The mission of the Clackamas County Juvenile Department ("CCJD") is to provide equitable juvenile justice, family support, intervention, and reformation services to youth so they can repair harm to victims, experience positive change, and contribute to a safe, healthy, and secure community.

CCJD supports a system of interventions that addresses a youth's risk factors and supports success for that youth. Youth are to be served in the most developmentally appropriate, least restrictive, and most cost-effective level of intervention. To support these youth, CCJD utilizes assessment and evaluation residential service resources for youth not able to be safely returned to their families and are not suitable for other short-term residential placement services, or juvenile detention.

The Oregon Health Authority (OHA) amendment number 1 to Intergovernmental Agreement (IGA) 167781 with Oregon Health Authority (OHA) adds partial Medicaid reimbursement for Assessment and Evaluation Services daily bed costs for eligible youth. A local fund match is required prior to reimbursement. There is not a limit on the amount of reimbursement available per the IGA. The net reimbursement, after the match, is approximately 35.5% of the current cost per day. The estimated possible annual net revenue for 100% utilization of the 1.2 assessment and evaluation service beds contracted with Multnomah County equals $44,935. The actual net revenue received is based solely on utilization of these assessment and evaluation residential service beds by eligible youth.

RECOMMENDATION:

Staff recommends the Board approval of the amendment to the IGA with Oregon Health Authority to continue to receive reimbursement for these residential program costs.

Respectfully submitted,

Christina L. McMahan, Director
Juvenile Department

Agreement Number 167781

AMENDMENT TO
STATE OF OREGON
INTERGOVERNMENTAL AGREEMENT

In compliance with the Americans with Disabilities Act, this document is available in alternate formats such as Braille, large print, audio recordings, Web-based communications and other electronic formats. To request an alternate format, please send an e-mail to dhs-oha.publicationrequest@state.or.us or call 503-378-3486 (voice) or 503-378-3523 (TTY) to arrange for the alternative format.

This is amendment number **1** to Agreement Number **167781** between the State of Oregon, acting by and through its Oregon Health Authority, hereinafter referred to as "OHA" and

Clackamas County
Acting by and through its Juvenile Department
2121 Kaen Road
Oregon City, Oregon 97045
Attention: Christina McMahan, Ed Jones
Telephone: (503) 650-3180
E-mail address: cmcmahan@clackamas.us , ejones@clackamas.us

hereinafter referred to as "County."

1. This amendment shall become effective on the date this amendment has been fully executed by every party and, when required, approved by Department of Justice.

2. The Agreement is hereby amended as follows:

a. Exhibit A Part 1 "Statement of Work" section 1. a. only is amended as follows, new language is **underlined and bold**.

1. County shall:

a. Provide Shelter Services **and Assessment and Evaluation Services** as defined in, and in accordance with Oregon Administrative Rules (OAR) 410-170-0000 through 410-170-0120 for Behavior Rehabilitation Services (BRS).

3. Except as expressly amended above, all other terms and conditions of the original Agreement and any previous amendments are still in full force and effect. County certifies that the representations, warranties and certifications contained in the original Agreement are true and correct as of the effective date of this amendment and with the

same effect as though made at the time of this amendment.

4. Certification. Without limiting the generality of the foregoing, by signature on this Agreement, the County hereby certifies under penalty of perjury that:

a. The County is in compliance with all insurance requirements of Exhibit C of the original Agreement and notwithstanding any provision to the contrary, County shall deliver to the OHA Agreement Administrator (see page 1 of this Agreement) the required Certificate(s) of Insurance for any extension of the insurance coverage required by Exhibit C of the original Agreement, within 30 days of execution of the original Agreement Amendment. By certifying compliance with all insurance as required by this Agreement, County acknowledges it may be found in breach of the Agreement for failure to obtain required insurance. County may also be in breach of the Agreement for failure to provide Certificate(s) of Insurance as required and to maintain required coverage for the duration of the Agreement;

b. The County acknowledges that the Oregon False Claims Act, ORS 180.750 to 180.785, applies to any "claim" (as defined by ORS 180.750) that is made by (or caused by) the County and that pertains to this Agreement or to the project for which the Agreement work is being performed. The County certifies that no claim described in the previous sentence is or will be a "false claim" (as defined by ORS 180.750) or an act prohibited by ORS 180.755. County further acknowledges that in addition to the remedies under this Agreement, if it makes (or causes to be made) a false claim or performs (or causes to be performed) an act prohibited under the Oregon False Claims Act, the Oregon Attorney General may enforce the liabilities and penalties provided by the Oregon False Claims Act against the County;

c. The information shown in County Data and Certification, of original Agreement or as amended is County's true, accurate and correct information;

d. To the best of the undersigned's knowledge, County has not discriminated against and will not discriminate against minority, women or emerging small business enterprises certified under ORS 200.055 in obtaining any required subcontracts;

e. County and County's employees and agents are not included on the list titled "Specially Designated Nationals" maintained by the Office of Foreign Assets Control of the United States Department of the Treasury and currently found at: *https://www.treasury.gov/resource-center/sanctions/SDN-List/Pages/default.aspx*;

f. County is not listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal procurement or Nonprocurement Programs" found at: *https://www.sam.gov/portal/public/SAM/*;

g. County is not subject to backup withholding because:

(1) County is exempt from backup withholding;

(2) County has not been notified by the IRS that County is subject to backup withholding as a result of a failure to report all interest or dividends; or

(3) The IRS has notified County that County is no longer subject to backup withholding.

h. County Federal Identification Number (FEIN) provided to OHA is true and accurate. If this information changes, County is also required to provide OHA with the new FEIN within 10 days.

4. County Data. This information is requested pursuant to ORS 305.385.

PLEASE PRINT OR TYPE THE FOLLOWING INFORMATION:

County Name (exactly as filed with the IRS): Clackamas County

Street address: 2051 Kaen Road

City, state, zip code: Oregon City, OR 97045

Email address: EJones@clackamas.us

Telephone: (503) 650-3169 Facsimile: (503) 655-8448

Proof of Insurance: County shall provide the following information upon submission of the signed Agreement amendment. All insurance listed herein and required by Exhibit C of the original Agreement, must be in effect prior to Agreement execution.

Workers' Compensation Insurance Company: Self-insured

Policy #: _____ Expiration Date: _____

5. Signatures.

COUNTY: YOU WILL NOT BE PAID FOR SERVICES RENDERED PRIOR TO NECESSARY STATE APPROVALS

Clackamas County
Acting by and through its Juvenile Department
By:

Authorized Signature	Printed Name
Title	Date

State of Oregon acting by and through its Oregon Health Authority
By:

Authorized Signature	Printed Name
Title	Date

Approved for Legal Sufficiency:

Ellen D. Taussig Conaty via email on October 27, 2021

Assistant Attorney General — Date
Oregon Department of Justice

DOCUMENT RETURN STATEMENT

Please complete the following statement and return with the completed signature page and the Contractor Data and Certification page and/or Contractor Tax Identification Information (CTII) form, if applicable.

If you have any questions or find errors in the above referenced Document, please contact the contract specialist.

Document number: 167781-1 , hereinafter referred to as "Document."

I, Tootie Smith (Name) Chair (Title)

received a copy of the above referenced Document, between the State of Oregon, acting by and through the Department of Human Services, the Oregon Health Authority, and

Clackamas County by email.

Contractor's name

On _____ ,
Date

I signed the electronically transmitted Document without change. I am returning the completed signature page, Contractor Data and Certification page and/or Contractor Tax Identification Information (CTII) form, if applicable, with this Document Return Statement.

_____ _____
Authorizing signature Date

Please attach this completed form with your signed document(s) and return to the contract specialist via email.

CLACKAMAS COUNTY

CHRISTINA L. MCMAHAN
DIRECTOR

JUVENILE DEPARTMENT
JUVENILE INTAKE AND ASSESSMENT CENTER
2121 KAEN ROAD | OREGON CITY, OR 97045

December 2, 2021

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of Intergovernmental Agreement with the State of Oregon Acting by and through its Oregon Youth Authority for Individualized Services

Purpose/ Outcomes	This Intergovernmental Agreement between the State of Oregon, by and through Oregon Youth Authority, and Clackamas County provides reimbursement dollars for Individualized Services.
Dollar Amount and Fiscal Impact	State of Oregon will provide up to $76,163 to the Department. There are no general fund dollars required.
Funding Source	State of Oregon
Duration	Effective July 1, 2021 through June 30, 2023.
Previous Board Action	The previous Intergovernmental Agreements (IGA) for this revenue was IGA number 13191 signed by John Ludlow, Chair, on 7/16/15, IGA number 13736 was signed by Jim Bernard, Chair, on 6/29/17, IGA number 14318 was signed by Jim Bernard, Chair, on 10/31/19 .
Strategic Plan Alignment	1. Provide intervention, accountability and support services to youth referred to the Department so they can stop committing offenses, understand the impact of their actions, repair harm and make positive change. 2. Ensure safe, healthy and secure communities.
Counsel Review	11/3/2021 Counsel Initials: JM
Procurement Review	Was the item processed through Procurement? ☐ yes ☒ no This item is an IGA.
Contact Person	Ed Jones, Administrative Services Manager 503-650-3169
Contract No.	14719

BACKGROUND:
The mission of the Clackamas County Juvenile Department ("CCJD") is to provide equitable juvenile justice, family support, intervention, and reformation services to youth so they can repair

harm to victims, experience positive change, and contribute to a safe, healthy, and secure community.

This Intergovernmental Agreement provides funds for individual services for adjudicated youth and their families. Such services include psychological evaluations, therapy, GED testing and classes, bus passes, various pro-social activities and/or classes, polygraph tests, etc. The County works to provide youth-specific, comprehensive wrap around services for youth who are eligible for these services. In order to be eligible, a youth must be adjudicated delinquent and in need of services that cannot be funded through any other source, public or private, in any other way. Youth must be at risk of commitment to the Oregon Youth Authority (OYA), an OYA youth correctional facility, or at risk of recommitment/revocation to an OYA youth correctional facility.

RECOMMENDATION:

Staff recommends the Board of County Commissioners approve the attached Intergovernmental Agreement.

Respectfully submitted,

Christina L. McMahan, Director
Juvenile Department

In compliance with the Americans with Disabilities Act, this document is available in alternate formats such as Braille, large print, audio tape, oral presentation, and computer disk. To request an alternate format call the State of Oregon, Oregon Youth Authority, Procurement Unit at (503) 373-7371.

STATE OF OREGON
INTERGOVERNMENTAL AGREEMENT
INDIVIDUALIZED SERVICES

Agreement # 14719

This Agreement is between the State of Oregon, acting by and through its **Oregon Youth Authority**, hereafter called "**OYA**" or "**Agency"**, and **Clackamas County**, hereafter called **"County",** both individually without distinction as "Party" and collectively as the "Parties."

Agency's **Agreement Administrator** for this Agreement is:
Laura Ward
Phone Number: (503) 373-7125
Address: 530 Center St NE, Suite 500, Salem, Oregon 97301

1. Effective Date and Duration. Upon receipt of all required approvals and execution by all parties, this Agreement shall be effective **July 1, 2021.** Unless extended or terminated earlier in accordance with its terms, this Agreement shall terminate when Agency accepts County's completed performance or on **June 30, 2023**, whichever date occurs first. Agreement termination shall not extinguish or prejudice Agency's right to enforce this Agreement with respect to any default by County that has not been cured.

2. Statement of Work. County shall perform the work (the "Work" or "Service") as set forth in the Statement of Work, which includes the delivery schedule for such Work, and that is attached hereto as Exhibit A. County shall perform the Work in accordance with the terms and conditions of this Agreement.

3. Consideration
a. The maximum, not-to-exceed compensation payable to County under this Agreement, which includes any allowable expenses, is **$76,163.00.** Agency will not pay County any amount in excess of the not-to-exceed compensation of this Agreement for completing the Work, and will not pay for Work performed before the date this Agreement becomes effective or after the termination of this Agreement. If the maximum compensation is increased by amendment of this Agreement, the amendment must be fully effective before County performs Work subject to the amendment.
b. Interim payments to County shall be subject to ORS 293.462, and shall be made in accordance with the payment schedule and requirements in Exhibit A.
c. Agency will pay only for completed Work that is accepted by Agency.

4. Documents. This Agreement consists of the following documents, which are listed in descending order of precedence: this Agreement less all exhibits, Exhibit A (the Statement of Work), Exhibit B (Subcontractor Requirements) and Exhibit C (Service Tracking in JJIS). Exhibit A, B and C are attached hereto and incorporated herein by this reference.

5. Independent Contractor; Responsibility for Taxes and Withholding
a. County shall perform all Work as an independent contractor. The Agency reserves the right (i) to determine and modify the delivery schedule for the Work and (ii) to evaluate the quality of the Work Product, however, the Agency may not and will not control the means or manner of County's performance. County is responsible for determining the appropriate means and manner of performing the Work.
b. If County is currently performing work for the State of Oregon or the federal government, County by signature to this Agreement, represents and warrants that: County's Work to be performed under this Agreement creates no potential or actual conflict of interest as defined by ORS 244 and no statutes, rules or regulations of the state or federal agency for which County currently performs work would prohibit County's Work under this Agreement.
c. The parties agree and acknowledge that their relationship is that of independent contracting parties and that County is an "officer", "employee", or "agent" of the Agency, as those terms are used in ORS 30.265 or otherwise.
d. County shall be responsible for all federal or state taxes applicable to compensation or payments paid to County under this Agreement and, unless County is subject to backup withholding, Agency will not withhold from such compensation

or payments any amount(s) to cover County's federal or state tax obligations. County is not eligible for any social security, unemployment insurance or workers' compensation benefits from compensation or payments paid to County under this Agreement, except as a self-employed individual.

6. Subcontracts, Successors, and Assignments

a. County may contract with a third person or entity (a "Subcontractor") for delivery of a particular Service or portion thereof (a "Subcontract"). County may permit a Subcontractor to subcontract with a third person or entity for delivery of a particular Service or portion thereof and such subcontractors shall also be considered Subcontractors for purposes of this Agreement and the subcontracts shall be considered Subcontracts for purposes of this Agreement. County shall not permit any person or entity to be a Subcontractor unless the person or entity holds all licenses, certificates, authorizations and other approvals required by applicable law to deliver the Service. County shall ensure that the Subcontract is in writing and contains all provisions of this Agreement necessary for County to comply with its obligations under this Agreement and applicable to the Subcontractor's performance under the Subcontract, including but not limited to, all provisions of this Agreement that expressly require County to require Subcontractor's compliance with respect thereto. County shall maintain an originally executed copy of each Subcontract at its office and shall furnish a copy of any Subcontract to the Agency upon request.

b. County shall not assign, delegate or transfer its interest in this Agreement without prior written approval of Agency. Any such assignment or transfer, if approved, is subject to such conditions and provisions as the Agency may deem necessary. No approval by the Agency of the assignment or transfer of interest shall be deemed to create any obligation of the Agency in addition to those set forth in the Agreement.

c. The provisions of this Agreement shall be binding upon and shall inure to the benefit of the parties hereto and their respective successors, and permitted assigns.

7. No Third Party Beneficiaries. The Agency and County are the only parties to this Agreement and are the only parties entitled to enforce its terms. The parties agree that County's performance under this Agreement is solely for the benefit of the Agency to assist and enable the Agency to accomplish its statutory mission. Nothing in this Agreement gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly, indirectly or otherwise, to third persons any greater than the rights and benefits enjoyed by the general public unless such third persons are individually identified by name herein and expressly described as intended beneficiaries of the terms of this Agreement.

8. Funds Available and Authorized; Payments. County shall not be compensated for Work performed under this Agreement by any other agency or department of the State of Oregon. Agency certifies that it has sufficient funds currently authorized for expenditure to finance the costs of this Agreement within the Agency's current biennial appropriation or limitation. County understands and agrees that Agency's payment of amounts under this Agreement is contingent on Agency receiving appropriations, limitations, allotments or other expenditure authority sufficient to allow Agency, in the exercise of its reasonable administrative discretion, to continue to make payments under this Agreement.

9. Representations and Warranties. County represents and warrants to Agency as follows:

a. Organization and Authority. County is a political subdivision of the State of Oregon duly organized and validly existing under the laws of the State of Oregon. County has full power, authority and legal right to make this Agreement and to incur and perform its obligation hereunder.

b. Due Authorization. The making and performance by County of this Agreement (1) have been duly authorized by all necessary action of County and (2) do not and will not violate any provision of any applicable law, rule, regulation, or order of any court, regulatory commission, board, or other administrative agency or any provision of County's charter or other organizational document and (3) do not and will not result in the breach of, or constitute a default or require any consent under any other agreement or instrument to which County is a party or by which County or any of its properties may be bound or affected. No authorization, consent, license, approval of, filing or registration with or notification to any other governmental body or regulatory or supervisory authority is required for the execution, delivery or performance by County of this Agreement.

c. Binding Obligation. This Agreement has been duly executed and delivered by County and constitutes a legal, valid and binding obligation of County, enforceable in accordance with its terms subject to the laws of bankruptcy, insolvency, or other similar laws affecting the enforcement of creditors' rights generally.

d. Accuracy of Information. The statements made in and the information provided in connection with any applications, requests or submissions to the State hereunder or in connection with any funding provided to County hereunder are true and accurate in all materials respects.

e. Services. The delivery of each Service will comply with the terms and conditions of this Agreement and meet the standards for such Service as set forth herein, including but not limited to, any terms, conditions, standards and requirements set forth in Exhibit A.

f. The warranties set forth above are in addition to, and not in lieu of, any other warranties set forth in this Agreement or implied by law.

10. Ownership of Intellectual Property.

a. Except as otherwise expressly provided herein, or as otherwise provided by state or federal law, OYA will not own the right, title and interest in any intellectual property created or delivered by County or a Subcontractor in connection with the Services. With respect to that portion of the intellectual property that the County owns, County grants to OYA a perpetual, worldwide, non-exclusive, royalty-free and irrevocable license, subject to any provisions in the Agreement that restrict or prohibit dissemination or disclosure of information, to (i) use, reproduce, prepare derivative works based upon, distribute copies of, perform and display the intellectual property, (ii) authorize third parties to exercise the rights set forth in Section 10.a(i) on OYA's behalf, and (iii) sublicense to third parties the rights set forth in Section 10a(i).

b. If state or federal law requires that OYA or County grant to the United States a license to any intellectual property or if state or federal law requires that OYA or the United States own the intellectual property, then County shall execute such further documents and instruments as OYA may reasonably request in order to make any such grant or to assign ownership in the intellectual property to the United States or OYA. To the extent that OYA becomes the owner of any intellectual property created or delivered by County in connection with the Services, OYA will grant a perpetual, worldwide, non-exclusive, royalty-free and irrevocable license, subject to any provisions in the Agreement that restrict or prohibit dissemination or disclosure of information, to County to use, copy, distribute, display, build upon and improve the intellectual property.

c. County shall include in its Subcontracts terms and conditions necessary to require that Subcontractors execute such further documents and instruments as OYA may reasonably request in order to make any grant of license or assignment of ownership that may be required by federal or state law or otherwise requested by OYA.

11. Contribution

a. If any third party makes any claim or brings any action, suit or proceeding alleging a tort as now or hereafter defined in ORS 30.260 ("Third Party Claim") against a party (the "Notified Party") with respect to which the other party ("Other Party") may have liability, the Notified Party must promptly notify the Other Party in writing of the Third Party Claim and deliver to the Other Party, along with the written notice, a copy of the claim, process, and all legal pleadings with respect to the Third Party Claim that have been received by the notified party. Each party is entitled to participate in the defense of a Third Party Claim, and to defend a Third Party Claim with counsel of its own choosing. Receipt by the Other Party of the notice and copies required in this Section and meaningful opportunity for the Other Party to participate in the investigation, defense and settlement of the Third Party Claim with counsel of its own choosing are conditions precedent to the Other Party's contribution obligations under this Section with respect to the Third Party Claim.

b. With respect to a Third Party Claim for which the State is jointly liable with the County (or would be if joined in the Third Party Claim), the State shall contribute to the amount of expenses (including attorneys' fees), judgments, fines and amounts paid in settlement actually and reasonably incurred and paid or payable by the County in such proportion as is appropriate to reflect the relative fault of the State on the one hand and of the County on the other hand in connection with the events which resulted in such expenses, judgments, fines or settlement amounts, as well as any other relevant equitable considerations. The relative fault of the State on the one hand and of the County on the other hand shall be determined by reference to, among other things, the parties' relative intent, knowledge, access to information and opportunity to correct or prevent the circumstances resulting in such expenses, judgments, fines or settlement amounts. The State's contribution amount in any instance is capped to the same extent it would have been capped under Oregon law if the State had sole liability in the proceeding.

c. With respect to a Third Party Claim for which the County is jointly liable with the State (or would be if joined in the Third Party Claim), the County shall contribute to the amount of expenses (including attorneys' fees), judgments, fines and amounts paid in settlement actually and reasonably incurred and paid or payable by the State in such proportion as is appropriate to reflect the relative fault of the County on the one hand and of the State on the other hand in connection with the events which resulted in such expenses, judgments, fines or settlement amounts, as well as any other relevant equitable considerations. The relative fault of the County on the one hand and of the State on the other hand shall be determined by reference to, among other things, the parties' relative intent, knowledge, access to information and opportunity to correct or prevent the circumstances resulting in such expenses, judgments, fines or settlement amounts. The County's contribution amount in any instance is capped to the same extent it would have been capped under Oregon

law if it had sole liability in the proceeding.

12. Default; Remedies; Termination.

a. Default by County. County shall be in default under this Agreement upon the occurrence of any of the following events:

(i) County fails to perform, observe or discharge any of its covenants, agreements or obligations set forth herein, including but not limited to, County's failure to comply with the Individualized Services Referral form;

(ii) Any representation, warranty or statement made by County herein or in any documents or reports relied upon by Agency to measure the delivery of Services, the expenditure of funds or the performance by County is untrue in any material respect when made;

(iii) County (i) applies for or consents to the appointment of, or taking of possession by, a receiver, custodian, trustee, or liquidator of itself or all of its property, (ii) admits in writing its inability, or is generally unable, to pay its debts as they become due, (iii) makes a general assignment for the benefit of its creditors, (iv) is adjudicated a bankrupt or insolvent, (v) commences a voluntary case under the Federal Bankruptcy Code (as now or hereafter in effect), (vi) files a petition seeking to take advantage of any other law relating to bankruptcy, insolvency, reorganization, winding-up, or composition or adjustment of debts, (vii) fails to controvert in a timely and appropriate manner, or acquiesces in writing to, any petition filed against it in an involuntary case under the Bankruptcy Code, or (viii) takes any action for the purpose of effecting any of the foregoing; or

(iv) A proceeding or case is commenced, without the application or consent of County, in any court of competent jurisdiction, seeking (i) the liquidation, dissolution or winding-up, or the composition or readjustment of debts, of County, (ii) the appointment of a trustee, receiver, custodian, liquidator, or the like of County or of all or any substantial part of its assets, or (iii) similar relief in respect to County under any law relating to bankruptcy, insolvency, reorganization, winding-up, or composition or adjustment of debts, and such proceeding or case continues un-dismissed, or an order, judgment, or decree approving or ordering any of the foregoing is entered and continues unstayed and in effect for a period of sixty consecutive days, or an order for relief against County is entered in an involuntary case under the Federal Bankruptcy Code (as now or hereafter in effect).

b. Agency's Remedies for County's Default. In the event County is in default under Section 12.a, Agency may, at its option, pursue any or all of the remedies available to it under this Agreement and at law or in equity, including, but not limited to:

(i) termination of this Agreement under Section 12.e(ii)(D), (E), or (F);

(ii) withholding all monies due for Work and Work Products that County has failed to deliver within any scheduled completion dates or has performed inadequately or defectively;

(iii) initiation of an action or proceeding for damages, specific performance, or declaratory or injunctive relief;

(iv) exercise of its right of setoff.

These remedies are cumulative to the extent the remedies are not inconsistent, and Agency may pursue any remedy or remedies singly, collectively, successively or in any order whatsoever. If a court determines that County was not in default under Section 12.a, then County shall be entitled to the same remedies as if this Agreement was terminated pursuant to Section 12.e(ii)(A), (B), or (C).

c. Agency Default. Agency shall be in default under this Agreement upon the occurrence of any of the following events:

(i) Agency fails to perform, observe or discharge any of its covenants, agreements, or obligations set forth herein; or

(ii) Any representation, warranty or statement made by Agency herein is untrue in any material respect when made.

d. County's Remedies for Agency's Default. In the event Agency terminates the Agreement under Section 12.e(ii)(A), (B), or (C), or in the event Agency is in default under Section 12.c and whether or not County elects to exercise its right to terminate the Agreement under Section 12.e(i)(B), County's sole monetary remedy shall be (a) with respect to services compensable on an hourly basis, a claim for unpaid invoices, hours worked within any limits set forth in this Agreement but not yet billed, authorized expenses incurred and interest within the limits permitted under ORS 293.462, and (b) with respect to deliverable-based Work, a claim for the sum designated for completing the deliverable multiplied by the percentage of Work completed and accepted by Agency, less previous amounts paid and any claim(s) that Agency has against County. In no event shall Agency be liable to County for any expenses related to termination of this Agreement or for anticipated profits. If previous amounts paid to County exceed the amount due to County under this Section 12.d, County shall pay immediately any excess to Agency upon written demand.

e. Termination.

(i) County Termination. County may terminate this Agreement:

(A)In its entirety for its convenience, upon 90 days advance written notice to the Agency.

(B)Upon 30 days advance written notice to Agency, if Agency is in default under this Agreement and such default remains uncured at the end of said 30 day period or such longer period, if any, as County may specify in the notice.

(C)Upon 45 days advance written notice to Agency, if County does not obtain funding, appropriations and other expenditure authorizations from County's governing body, federal, state or other sources sufficient to permit County to satisfy its performance obligations under this Agreement, as determined by County in the reasonable exercise of its administrative discretion.

(D)Immediately upon written notice to Agency, if Oregon statutes or federal laws, regulations or guidelines are modified, changed or interpreted in such a way that County no longer has the authority to meet its obligations under this Agreement.
(ii) Agency's Termination. Agency may terminate this Agreement in its entirety or may terminate its obligation to provide funds under any portion of this Agreement:
(A) Upon 90 days' advance written notice to County, if Agency determines, in its sole discretion, to end all or any portion of the funds to County under this Agreement.
(B) Upon 45 days written notice to County, if Agency does not obtain funding, appropriations and other expenditure authorizations from federal, state or other sources sufficient, in the exercise of Agency's reasonable administrative discretion, to meet the payment obligations of Agency under this Agreement.
(C) Immediately upon written notice if state or federal laws, regulations, or guidelines are modified changed or interpreted in such a way that the Agency does not have the authority to provide funds for one or more Services or no longer has the authority to provide the funds from the funding source it had planned to use.
(D) Upon 30 days advance written notice to County, if County is in default under this Agreement and such default remains uncured at the end of said 30 day period or such longer period, if any, as Agency may specify in the notice.
(E) Immediately upon written notice to County, if any license or certificate required by law or regulation to be held by County or a subcontractor to deliver a Service is for any reason denied, revoked, suspended, not renewed or changed in such a way that County or a subcontractor no longer meets requirements to deliver the Service. This termination right may only be exercised with respect to the particular group of Services impacted by loss of necessary licensure or certification.
(F) Immediately upon written notice to County, if Agency determines that County or any of its subcontractors have endangered or are endangering the health or safety of a Client or others.
(iii) Entire Agreement. Upon termination of this Agreement in its entirety, Agency shall have no further obligation to pay funds to County under this Agreement, whether or not Agency has paid to County all funds described in Exhibit A. Notwithstanding the foregoing, Agency shall make payments to reimburse County's for services provided prior to the effective date of termination where such services are authorized pursuant to this Agreement and are not disputed by Agency.

13. Limitation of Liabilities. EXCEPT FOR LIABILITY OF DAMAGES ARISING OUT OF OR RELATED TO SECTION 11, NEITHER PARTY SHALL BE LIABLE TO THE OTHER FOR ANY INCIDENTAL OR CONSEQUENTIAL DAMAGES ARISING OUT OF OR RELATED TO THIS AGREEMENT. NEITHER PARTY SHALL BE LIABLE FOR ANY DAMAGES OF ANY SORT ARISING SOLELY FROM THE TERMINATION OF THIS AGREEMENT OR ANY PART HEREOF IN ACCORDANCE WITH ITS TERMS.

14. Records Maintenance; Access. County shall maintain, and require all subcontractors to maintain, all financial records relating to this Agreement or any subcontractor contract in accordance with generally accepted accounting principles. In addition, County shall maintain and require all subcontractors to maintain, any other records (including but not limited to statistical records) pertinent to this Agreement in such a manner as to clearly document County's and each subcontractor's performance. County acknowledges and agrees that Agency and the Oregon Secretary of State's Office and the federal government and their duly authorized representatives shall have access to such fiscal and statistical records and other books, documents, papers, plans and writings of County that are pertinent to this Agreement to perform examinations, audits and program reviews and make excerpts and transcripts. A copy of an audit or report will be made available to County. County shall retain and keep accessible all such fiscal and statistical records, books, documents, papers, plans, and writings for a minimum of six (6) years, or such longer period as may be required by applicable law, following final payment and termination of this Agreement, or until the conclusion of any audit, controversy or litigation arising out of or related to this Agreement, whichever date is later.

15. Compliance with Applicable Law. County shall comply and require all subcontractors to comply with all federal, state and local laws, regulations, executive orders and ordinances applicable to the Agreement or to the delivery of Services. Without limiting the generality of the foregoing, County expressly agrees to comply with the following laws, regulations and executive orders to the extent they are applicable to the Agreement: (i) Titles VI and VII of the Civil Rights Act of 1964, as amended; (ii) Sections 503 and 504 of the Rehabilitation Act of 1973, as amended; (iii) the Americans with Disabilities Act of 1990, as amended; (iv) Executive Order 11246, as amended; (v) the Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act portion of the American Recovery and Reinvestment Act of 2009 (ARRA), including the Privacy and Security Rules found at 45 CFR Parts 160 and 164, as the law and its implementing regulations may be updated from time to time; (vi) the Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended; (vii) the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended; (viii) ORS Chapter 659, as amended; (ix) all regulations and administrative rules established pursuant to

the foregoing laws; and (x) all other applicable requirements of federal and state civil rights and rehabilitation statutes, rules and regulations. These laws, regulations and executive orders are incorporated by reference herein to the extent that they are applicable to the Agreement and required by law to be so incorporated. Agency's performance under the Agreement is conditioned upon County's compliance with the provisions of ORS 279B.220, 279B.230 and 279B.235, which are incorporated by reference herein. County shall, to the maximum extent economically feasible in the performance of this Agreement, use recycled paper (as defined in ORS 279A.010(1)(gg)), recycled PETE products (as defined in ORS 279A.010(1)(hh)), and other recycled products (as "recycled product" is defined in ORS 279A.010(1)(ii)).

16. Force Majeure. Neither Agency nor County shall be held responsible for delay or default caused by fire, civil unrest, labor unrest, natural causes, terrorist acts and other acts of political sabotage, and war which is beyond respectively, the Agency's or County's reasonable control. Each party shall, however, make all reasonable efforts to remove or eliminate such cause of delay or default and shall, upon the cessation of the cause, diligently pursue performance of its obligations under this Agreement.

17. Survival. All rights and obligations shall cease upon termination or expiration of this Agreement, except for the rights and obligations set forth in Sections 1, 7, 8, 9, 10, 11, 12, 13, 14, 17, 20, 21, 22 and 24.

18. Notice. Except as otherwise expressly provided in this Agreement, any communications between the parties hereto or notices to be given hereunder shall be given in writing, by personal delivery, facsimile, electronic mail, or mailing the same, postage prepaid, to County or Agency at the address or number set forth in this Agreement, or to such other addresses or numbers as either party may indicate pursuant to this Section 18. Any communication or notice so addressed and mailed shall be effective five (5) days after mailing. Any communication or notice delivered by facsimile shall be effective on the day the transmitting machine generates a receipt of the successful transmission, if transmission was during normal business hours of the recipient, or on the next business day, if transmission was outside normal business hours of the recipient. Any communication or notice delivered by electronic mail shall be effective on the day of notification of delivery to the recipient's e-mail system. Any communication or notice given by personal delivery shall be effective when actually delivered.

19. Severability. The parties agree that if any term or provision of this Agreement is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and provisions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the Agreement did not contain the particular term or provision held to be invalid.

20. Counterparts. This Agreement may be executed in several counterparts, all of which when taken together shall constitute one agreement binding on all parties, notwithstanding that all parties are not signatories to the same counterpart. Each copy of the Agreement so executed shall constitute an original.

21. Governing Law; Consent to Jurisdiction. This Agreement shall be governed by and construed in accordance with the laws of the State of Oregon without regard to principles of conflicts of law. Any claim, action, suit or proceeding (collectively, "Claim") between Agency (and/or any other agency or department of the State of Oregon) and County that arises from or relates to this Agreement shall be brought and conducted solely and exclusively within a Circuit Court in the State of Oregon; provided, however, if a Claim must be brought in a federal forum, then it shall be brought and conducted solely and exclusively within the United States District Court for the District of Oregon. In no event shall this Section be construed as a waiver by the State of Oregon of any form of defense or immunity, whether sovereign immunity, governmental immunity, immunity based on the eleventh amendment to the Constitution of the United States or otherwise, from any Claim or from the jurisdiction of any court. COUNTY, BY EXECUTION OF THIS AGREEMENT, HEREBY CONSENTS TO THE IN PERSONAM JURISDICTION OF SAID COURTS.

22. Integration and Waiver. This Agreement, including all of its Exhibits, constitutes the entire agreement between the parties on the subject matter hereof. There are no understandings, agreements, or representations, oral or written, not specified herein regarding this Agreement. The failure of either party to enforce any provision of this Agreement shall not constitute a waiver by that party of that or any other provision. The remedies provided herein are cumulative and not exclusive of any remedies provided by law.

23. Criminal History Checks: The Agency has statutory authority to access criminal offender information on all persons providing services under this Agreement (ORS 181A.010, 420A.010 (11) and 420A.021).

24. Confidentiality of Information.

a. The use or disclosure by the County and its employees and agents of any information concerning a recipient of Services, for any purpose not directly connected with the administration of the County's responsibilities with respect to such Services, is prohibited, except on written consent of the person or persons authorized by law to consent to such use or disclosure. The County shall prohibit the use or disclosure by the County's subcontractors and their employees and agents of any information concerning a recipient of Services provided under the applicable subcontracts, for any purpose not directly connected with the administration of the County's or subcontractor's responsibilities with respect to such Services, except on written consent of the person or persons authorized by law to consent to such use or disclosure. All records and files shall be appropriately secured to prevent access by unauthorized persons. The County shall, and shall require its subcontractors to, comply with all appropriate federal and state laws, rules and regulations regarding confidentiality of client records.
b. Agency shall include a provision in its contracts with contractors who utilize information related to the Services provided under this Agreement for research purposes, providing that contractor and its subcontractors under that contract shall not release confidential information on individual youth for purposes unrelated to the administration of the contract or required by applicable law, and a provision that contractor or its subcontractors under that contract shall appropriately secure all records and files to prevent access by unauthorized persons.
c. County shall maintain and require all Providers to maintain a Client record for each youth that receives a Service.

25. County-Client Relationship. The County shall establish a system approved by Agency through which a youth and the youth's parents or guardian may present grievances about the operation of the County's service program. At the time arrangements are made for the County's services, the County shall advise the youth and parents or guardian of the youth of the existence of this grievance system. The County shall notify the Agency of all unresolved grievances.

26. Program Records, Controls, Reports and Monitoring Procedures. The County shall maintain program records including statistical records, and provide program records to the Agency at times and in the form prescribed by the Agency. The County shall establish and exercise such controls as are necessary to assure full compliance with the program requirements of this Agreement. The County also agrees that a program and facilities review (including meetings with youth, review of service records, review of policy and procedures, review of staffing ratios and job descriptions, and meetings with any staff directly or indirectly involved in the provision of services) may be conducted at any reasonable time by any or all of the following: state personnel, federal personnel, and other persons authorized by the Agency. The County shall cooperate fully with such reviews.

27. Mandatory Reporting: As required by Oregon Law (ORS 419B.005 through ORS 419B.050), all OYA contractors must immediately inform either the local office of the Department of Human Services (DHS) or a law enforcement agency when they have reasonable cause to believe that any child with whom the County comes in contact has suffered abuse, or that any person with whom the County comes in contact has abused a child. Oregon Law recognizes child abuse to include but not be limited to: physical injury; neglect or maltreatment; sexual abuse and sexual exploitation; threat of harm; mental injury; child selling.

Reports must be made immediately upon awareness of the incident. Contractors are encouraged to contact the local DHS office if any questions arise as to whether an incident meets the definition of child abuse.

28. Amendments. No amendment, waiver, consent, modification or change of terms of this Agreement shall bind either party unless in writing and signed by all the parties and no such amendment, waiver, consent, modification, or change of terms shall be effective until all approvals required by law have been obtained from the Department of Justice. Such amendment, waiver, consent, modification or change if made, shall be effective only in the specific instance and for the specific purpose given.

29. Headings. The headings and captions to sections of this Agreement have been inserted for identification and reference purposes only and shall not be used to construe the meaning or to interpret this Agreement.

30. Construction. The parties agree and acknowledge that the rule of construction that ambiguities in a written agreement are to be construed against the party preparing or drafting the agreement shall not be applicable to the interpretation of this Agreement.

31. **HIPAA Compliance**. To the extent applicable, County shall deliver Services in compliance with the Health Insurance Portability and Accountability Act as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act portion of the American Recovery and Reinvestment Act of 2009 (ARRA), and the federal regulations implementing the Act, including the Privacy and Security Rules found at 45 CFR Parts 160 and 164, as the law and its

implementing regulations may be updated from time to time (collectively referred to as HIPAA). County shall comply and require all subcontractors to comply with the following:

a. Privacy and Security of Individually Identifiable Health Information. Individually Identifiable Health Information about specific individuals is confidential. Individually Identifiable Health Information relating to specific individuals may be exchanged between County and OYA for purposes directly related to the provision of Services. However, County shall not use or disclose any Individually Identifiable Health Information about specific individuals in a manner that would violate any applicable privacy rules.

b. Consultation and Testing. If County reasonably believes that County's delivery of Services under this Agreement may result in a violation of HIPAA requirements, County shall promptly consult with Agency.

32. Alternative Dispute Resolution

The parties should attempt in good faith to resolve any dispute arising out of this agreement. This may be done at any management level, including at a level higher than persons directly responsible for administration of the agreement. In addition, the parties may agree to utilize a jointly selected mediator or arbitrator (for non-binding arbitration) to resolve the dispute short of litigation.

COUNTY, BY EXECUTION OF THIS AGREEMENT, HEREBY ACKNOWLEDGES THAT COUNTY HAS READ THIS AGREEMENT, UNDERSTANDS IT, AND AGREES TO BE BOUND BY ITS TERMS AND CONDITIONS.

YOU WILL NOT BE PAID FOR SERVICES RENDERED PRIOR TO NECESSARY STATE APPROVALS

I hereby certify and affirm I am eligible and authorized to sign this agreement on behalf of the County.

By:_____ Date:_____

Title:_____

Mailing Address: 2121 Kaen Road

Oregon City, OR 97045

Facsimile: (503) 655-8448

AGENCY: STATE OF OREGON, acting by and through its Oregon Youth Authority

By:_____ Date:_____
Amber Forster, Designated Procurement Officer

Mailing Address: 530 Center St. NE, Suite 500
Salem, Oregon 97301-3740
Facsimile: (503) 373-7921

Approved as to Legal Sufficiency by the **Attorney General's Office:** (Required if total amount owing under the Agreement, including amendments, exceeds or is likely to exceed $150,000.00)

By: Exempt Per OAR 137-045-0050 Date:_____
Assistant Attorney General

Reviewed and Approved by **OYA Agreement Administrator:**

By: Template approved via email Date: 06032021
Laura Ward

Reviewed by **OYA Procurement Specialist:**

By:_____ Date:_____
Susanna Ramus

EXHIBIT A
STATEMENT OF WORK

1. STATEMENT OF WORK:

1.1 Overview: Individualized services funds are intended to purchase services to meet widely varied needs, ranging from simple one-time services/purchases to complex, multi-disciplinary case management services necessary to keep a youth offender in the community, prevent commitment to Oregon Youth Authority (OYA or Agency) Probation or placement in a youth correctional facility, or revocation/recommitment of a youth offender to an OYA youth correctional facility. Funds are not intended for routine and ongoing costs that are already built in to other payment structures such as ongoing clothing needs, grooming needs, student body cards, etc. Rather, they are intended to fill in where other funding sources are unavailable because of the uniqueness of the need. The purchase shall directly support a need specifically itemized in a case/reformation plan. County shall research and use other resources before using Individualized services funds. Individualized services are intended to be based on evidence-based principles.

Individualized services provided by the County shall have a holistic approach across the following case plan domains:

a) Medical;
b) Mental Health;
c) Social Living Skills;
d) Alcohol and Drug Treatment;
e) Education;
f) Vocational;
g) Family; and
h) Offense specific.

Individualized services requested shall be:

a) case-plan driven and community based;
b) based on evidenced-based principles;
c) outcome oriented;
d) proactive in approach (not crisis driven); and
e) culturally competent and gender specific.

1.2 Definition: For purposes of this Agreement, the term "youth offender" means "adjudicated youth" as that term is used in SB 436 (2021) in the event that SB 436 (2021) becomes law. This definition is effective on the date on which SB 436 is effective.

1.3 Eligibility: The County agrees to provide youth-specific, comprehensive wrap around services for youth who are eligible for Individualized services funds. Eligible youth are those youth who have been adjudicated delinquent; are in need of services that **cannot** be funded through any other source, public or private, in any other way and services are case plan driven; and are determined to:

a) be at risk of commitment to the OYA; or
b) be at risk of commitment to an OYA youth correctional facility; or
c) be at risk of recommitment/revocation to an OYA youth correctional facility.

Individualized Services funding may be authorized for services (otherwise authorized by the Individualized Services Handbook) to support a 'continued disposition' finding by the juvenile court. Documentation of continued disposition must be reflected in JJIS at the time of the service request. All service requests must be prior authorized by the OVA field supervisor.

1.4 Supervising Representatives: The Supervising Representatives for purposes of this Agreement shall be:

AGENCY: Peter Sprengelmeyer, Assistant Director, Community Services
530 Center Street NE, Suite 500, Salem, Oregon, 97301
(503) 373-7531
Peter.Sprengelmeyer@oya.state.or.us

COUNTY: Christina McMahon
2121 Kaen Road Oregon City, OR 97045
(503)655-8342x3171
CMcMahan@co.clackamas.or.us

Should a change in the Agency's or County's Supervising Representative or Agency's Agreement Administrator become necessary, Agency or County will notify the other party of such change. Such change shall be effective without the necessity of executing a formal amendment to this Agreement.

1.5 Services: The County's juvenile department staff shall be responsible for providing services to youth offenders referred for services under this Agreement. All referrals shall be submitted and approved using the Individualized Services Referral form as identified in subsection 1.6 of this Exhibit A. The services provided under this Agreement must:

be youth-specific;
a) provide direct support of the youth offender's specific case/reformation plan;
b) be utilized only when no other funding sources exist, public or private, for which the youth offender could qualify;
c) reflect a prudent expenditure of public funds and be within acceptable community norms;
d) present no threat to public safety; and
e) conform to the Agency's Individualized Services User Handbook. A copy of the Agency's Individualized Services User Handbook will be on file with the County and Agency.

1.6 Process: Individualized services expenditures must be approved in advance and in writing by a designee of the County and a designee of the Agency. The designee for both the County Juvenile Department and Agency shall be approved by the Agency's Supervising Representative of this Agreement.

1.7 Individualized Services Referral Form: Before any expenditures can be approved under this Agreement, the County, in consultation with the Agency, shall develop a form for each youth for whom Services are requested, titled "Individualized Services Referral" that shall be approved by the Agency Parole / Probation Supervisor or designee and Juvenile Department-designated representative for authorization of services under this Agreement. The form shall include:

a) a statement that services are being provided under the terms of this Agreement;
b) youth offender's Juvenile Justice Information System (JJIS) number;
c) name of the youth offender;
d) youth offender's date of birth;
e) basis of jurisdiction;
f) the signature of the requestor;
g) case/reformation plan domain and objective and how the requested service will aid in the accomplishment of that plan;
h) a description of the services to be provided;
i) the service provider selected;
j) unit cost;
k) number of units;
l) the total dollar amount of the services being requested;
m) beginning and ending dates for which the services are to be delivered; and
n) the approval signatures from a designated representative of both the County and the Agency.

County shall keep the detailed Individualized Services Referral form on file with the County and available for Agency review for a period of 24 months after the end date of this Agreement. County shall keep copies of the form available thereafter in the County's youth offender's case specific file.

1.8 Goals/Objectives: The goal of the expenditure of funds under this Agreement shall be to prevent the youth offender from further escalation into the Juvenile Justice System. Measurable progress toward these general goals shall be included in the synopsis as described in subsection 1.8 of this Exhibit A below. The goals for these funds include:

a) reduce commitments and revocations of youth offenders who can safely be managed in the community;
b) increase public safety by providing more appropriate services to youth offenders in the community;
c) increase positive reformation and evidenced-based reduction of risk;
d) decrease self-destructive behavior of youth offenders served;
e) increase educational participation of youth offenders served;
f) reduce the propensity of youth offenders to commit crimes;
g) increase the skills of youth offenders to appropriately live in a community setting; and
h) reduce the propensity of a youth offender to engage in antisocial behavior.

1.9 Synopsis: The County shall provide the Agency, **on a monthly or quarterly basis**, a synopsis of youth offenders who have been approved for the Individualized services funds during the previous month or quarter. The expenditure of Individualized service funds is directly related to the youth offender's case/reformation plan. All of the information required in the synopsis is available in the youth offender's case/reformation plan. The synopsis shall include:

a) the youth offender's JJIS number;
b) the youth offender's status (OYA, Juvenile Department);
c) the risk score from the Agency's adopted risk tool or the Oregon JCP Screen/Assessment instrument;
d) the date(s) services were provided;
e) the type of service authorized for the youth offender;
f) the service provider;
g) the total amount expended for the youth offender; and
h) a brief description of what domain and objective from the youth offender's case/reformation plan were met.

The synopsis shall be detailed and in the following format:

JJIS Number	Youth Status	Risk Score	Date(s) of Service	Type of Service	Service Provider	Amount Expended	Domain	Objective	OYA Agreement Number

The County shall provide additional youth offender specific and service specific information upon request by the Agency. County shall send the synopsis monthly or quarterly attached to the invoice to the Oregon Youth Authority, Supervising Representative per Subsection 1.3 of this Exhibit A.

1.10 Survey/Report: The Agency is periodically required to report information on how the Individualized service funds are utilized. To meet this requirement the Agency may periodically request a report from the County that may include all or a portion of the information reported in the synopsis. The County shall provide this report upon the Agency's request.

1.11 Verification of Service: The County by **submitting an invoice, completed Individualized Services Referral Form(s) and synopsis for reimbursement** is verifying that all services obtained for youth offenders under this Agreement have been provided as specified in the Individualized Services Referral form.

1.12 Other Funding Source Limits: Should a youth offender receiving services under this Agreement become eligible for services under any other private or public funding, then the services authorized by the Agreement for that specific youth offender shall be terminated and County shall not seek reimbursement for any future services so long as other funding exists.

1.13 Equal Access: The County agrees that there will be equal access to these funds for all adjudicated youths that have need for services under this Agreement. The County agrees that gender equity and diversity will be addressed appropriately and equitably.

1.14 Female Offenders: The Agency recognizes that female offender services continue to be more difficult to access; the use of Individualized services for female youth offenders will reflect services that offer specific and appropriate services for this population and employ service providers cognizant of female issues.

1.15 Evidence-Based Programs: County shall work with Agency to develop a process to ensure that programs and services funded under this Agreement are appropriate and workable and meet the guidelines of evidence-based programs and cost effectiveness as described under SB 267 (2003), ORS 182.515, as applicable. County shall work

with Agency to develop a reporting process on County's evidence-based programs and services funded under this Agreement. County shall submit such reports to the Agency on County's evidence-based programs and services funded under this Agreement at such frequency as may be requested by Agency.

1.16 Reporting and Documentation: During the term of this Agreement, County shall provide OYA with the necessary service information to track treatment and accountability services in JJIS, as defined by JJIS policy, Exhibit C "Service Tracking in JJIS" as it may be from time to time amended, or by service extracts, for progress in achieving the high level outcomes. This also applies to providing information on funded services not tracked in JJIS.

2. CONSIDERATION:

2.1 As consideration for the services provided by the County under this Agreement, the Agency, subject to the provision of ORS 293.462 (payment of overdue account charges) and the terms and conditions of this Agreement, will pay to the County, by warrant(s) an amount not to exceed **$76,163.00.**

2.2 The Agency reserves the right to deny payment for services provided that do not conform to the Agency's Individualized Services User Handbook, as may be revised from time to time.

2.3 Agency will reimburse County for all Allowable Costs that are authorized pursuant to this Agreement. "Allowable Costs" are defined as those costs which are reasonable and necessary for delivery of services under this Agreement, determined in accordance with 2 CFR Part 230 (Office of Management and Budget (OMB) Circular A 122) as revised from time to time. Agency will reimburse County for the Allowable Costs under this Agreement at the rates not to exceed those shown on the published OYA rate schedule or, if the services are not listed on the OYA rate schedule, then at the Oregon Medicaid rate, at the time services were provided. The rate schedule is available at http://www.oregon.gov/oya/Pages/contracts.aspx. When the rate schedule is revised, the County will be notified of the new rates. When determining appropriate providers for County adjudicated youth, County must be aware of any Agency contracts with the same providers and not agree to reimburse the provider for more than the comparable amount the provider charges the Agency for similar services.

2.4 It is agreed that any payment or reimbursement received by the County from a parent or guardian or any other personal entitlement received on behalf of any youth offender served under this Agreement shall be promptly remitted by the County to the Agency.

2.5 If the County allocates any indirect costs to this Agreement, the County shall make available to the Agency, upon request, a written cost allocation plan covering the handling and distribution of indirect costs. If all costs are direct costs to this Agreement, no cost allocation plan is required. In no event shall this subsection be construed to allow the County to require the Agency to pay any indirect costs allocated to this Agreement by County.

The County shall make available upon request by the Agency a monthly or quarterly detailed administrative financial report to support the actual monthly or quarterly administrative expenditures required under this Agreement.

2.6 The County agrees that the costs reimbursed by the Agency for services to youth offenders under this Agreement shall not exceed the costs for comparable services that are not covered by this Agreement.

2.7 The County will not impose or demand any fees from any person or agency (other than the Agency) for services provided and paid for under this Agreement, unless these fees have been approved in advance in writing by the Agency.

2.8 If, as a result of County's neglect or misconduct, the Agency terminates a youth offender's referral to the County under this Agreement, then the County shall no longer be entitled to reimbursement under this Agreement with respect to such youth offender after the date of such termination.

2.9 The County shall not use the funds provided hereunder to supplant money otherwise provided to the County Juvenile Department for services to delinquent youth.

3. PAYMENT:

3.1 County shall submit monthly or quarterly invoices along with the completed and approved Individualized Services Referral Form(s) described in subsection 1.6 and the attached synopsis as identified in subsection 1.8 of this Exhibit A, for Work performed for review and approval by the Agency. The invoices shall

describe the Work performed and the total amount for that month or quarter. The invoices shall be provided on a form provided by the Agency. County shall retain copies of the invoices and receipts in accordance with Section 14 of the Agreement and shall make available for review by Agency as described in subsection 3.5 of this Exhibit A. The invoices shall be prepared on Agency's form of invoice which County shall submit to: Oregon Youth Authority, Agency Parole / Probation Supervisor outlined in subsection 1.6 of this Exhibit A in accordance with Agency's instructions provided by Agency to County. Payment of any amount under this Agreement shall not constitute approval of the Work. The Agency's obligation to pay an invoice is conditioned upon the County providing the Agency with the synopsis specified in subsection 1.8 of this Exhibit A for the month or quarter for which payment is sought.

3.2 County shall not submit invoices for, and Agency will not pay, any amount in excess of the maximum compensation amount set forth above. If this maximum compensation amount is increased by amendment of this Agreement, the amendment must be fully effective before County performs services subject to the amendment. County shall notify Agency's Agreement Administrator in writing thirty (30) calendar days before this Agreement expires of the upcoming expiration of the Agreement. No payment will be made for any services performed before the beginning date or after the expiration date of this Agreement, as it may be amended from time to time in accordance with its terms.

3.3 If payments to County by the Agency under this Agreement are made in error or are found by the Agency to be excessive under the terms of this Agreement, the Agency, after giving written notification to the County, may withhold payments due to County under this Agreement in such amounts, and over such periods of time, as are deemed necessary by the Agency to recover the amount of the overpayment. This subsection 3.3 shall survive expiration or earlier termination of this Agreement and be fully enforceable thereafter.

3.4 County must submit its final invoice to the Agency no later than sixty (60) days after the expiration date of this Agreement. The Agency shall be under no obligation to pay for services not billed within sixty (60) days after the expiration date of this Agreement.

3.5 The Agency reserves the right to periodically audit and review the actual expenses of the County for the following purposes:

1) To document the relation between the established payments under this Agreement and the amounts spent by the County.
2) To document that the amounts spent by the County are reasonable and necessary to assure quality service.
3) To assure that the County's expenses are allowable in accordance with 2 CFR Part 225 or 2 CFR Part 230 (Federal OMB Circulars A-87 or A-122, respectively) on Allowable Costs. In the event a periodic audit and review by the Agency shows that the County's expenses are not allowable under 2 CFR Part 225 or 2 CFR Part 230 (Federal OMB Circulars A-87 or A-122, respectively) on Allowable Costs in any material respect, Agency may terminate this Agreement.

3.6 In addition to any other rights accorded to the Agency under this Agreement, if the County fails to comply with the provisions of subsections 2.3, 2.4, 2.6, 2.7 and 3.5 above, the Agency may terminate this Agreement pursuant to Section 12 e.(ii)(D) and invoke the remedies available to it, exercise its rights under subsection 3.3 of this Exhibit A, or both. Nothing in this provision shall require County or Agency to act in violation of state or federal constitutions, statutes, regulations or rules. The rights and remedies set forth in this Agreement are not intended to be exhaustive and the exercise by either party of any right or remedy does not preclude the exercise of any other rights or remedies at law or in equity.

3.7 If the Oregon Legislative Assembly, Legislative Emergency Board or Oregon Department of Administrative Services increases or decreases the amount of money appropriated or allotted for implementation of the Services under this Agreement, OYA may, by written notice to County, unilaterally increase or decrease the amount of the funding in this Agreement. In such circumstances, if requested by either party, the parties shall execute an amendment to this Agreement reflecting an increase or decrease in the funding implemented under this Section. Nothing in this Section shall limit or restrict OYA's rights under this Agreement to suspend payment of funds or to terminate this Agreement as a result of a reduction in appropriations or allotments. Notwithstanding the order of precedence listed in Section 4 of this Agreement, this Subsection 3.7 of this Exhibit A takes precedence over all other provisions of this Agreement including all Exhibits.

4. AMENDMENT:

This Agreement may be amended one or more times by mutual agreement of the Parties for time, money, terms, conditions, services, or any combination of the preceding. Any such amendment is not effective until approved by all parties and all necessary legal approvals have been obtained from the Department of Justice.

5. CONFLICT OF INTEREST

County shall notify Agency in writing when a current employee or newly hired employee is also an employee of the Agency. The notification shall be submitted to the Agreement Administrator and the OYA Procurement Unit and shall include the name of the employee and their job description. The Agency will review the employment situation for actual and potential conflicts of interest as identified under ORS Chapter 244.

6. EMERGENCY SUSPENSION/TERMINATION BY AGENCY

The parties understand and agree that under any of the following circumstances, without limitation, the Agency may remove or suspend a youth offender from services with the County immediately:

i. An allegation of child abuse/neglect or other conditions causing the Agency to determine that the youth offender's health, safety or welfare may be endangered; and
ii. An allegation of misconduct of County, County's employee or subcontractor causing the Agency to determine that the youth offender's health, safety or welfare may be endangered.

If as a result of County's alleged child abuse/neglect or misconduct, Agency suspends or terminates a youth offender's services with County in accordance with this Agreement, the County shall not be entitled to any compensation under this Agreement with respect to such youth from and after the date of such suspension or termination.

7. CRIMINAL HISTORY RECORDS CHECK

County shall ensure that, before any person provides unsupervised services under this Agreement, the person has passed a criminal history check based on Agency's criminal history records check standards as set forth in OAR 416-800-0000 to 416-800-0095.

Any person that has not yet passed a criminal history check must be supervised by a person who has passed such a test and does meet such standards, when having direct contact with Agency youth offenders under this Agreement. Any person that has failed a criminal history check as set forth in OAR 416-800-0000 to 416-800-0095 is prohibited from providing services under this Agreement to OYA youth offenders.

EXHIBIT B
SUBCONTRACTOR REQUIREMENTS

1. Indemnification by Subcontractors

County shall take all reasonable steps to cause its contractor(s) that are not units of local government as defined in ORS 190.003, if any, to indemnify, defend, save and hold harmless the State of Oregon and its officers, employees and agents ("Indemnitee") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including attorneys' fees) arising from a tort (as now or hereafter defined in ORS 30.260) caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of County's contractor or any of the officers, agents, employees or subcontractors of the contractor ("Claims"). It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by the contractor from and against any and all Claims.

2. Subcontractor Insurance Requirements

A. GENERAL.

County shall require its first tier contractor(s) (Contractor) that are not units of local government as defined in ORS 190.003, if any, to: i) obtain insurance specified under TYPES AND AMOUNTS and meeting the requirements under ADDITIONAL INSURED, "TAIL" COVERAGE, NOTICE OF CANCELLATION OR CHANGE, and CERTIFICATES OF INSURANCE before the contractors perform under contracts between County and the contractors (the "Subcontracts"), and ii) maintain the insurance in full force throughout the duration of the Subcontracts. The insurance must be provided by insurance companies or entities that are authorized to transact the business of insurance and issue coverage in the State of Oregon and that are acceptable to Agency. County shall not authorize contractors to begin work under the Subcontracts until the insurance is in full force. Thereafter, County shall monitor continued compliance with the insurance requirements on an annual or more frequent basis. County shall incorporate appropriate provisions in the Subcontracts permitting it to enforce contractor compliance with the insurance requirements and shall take all reasonable steps to enforce such compliance. Examples of "reasonable steps" include issuing stop work orders (or the equivalent) until the insurance is in full force or terminating the Subcontracts as permitted by the Subcontracts, or pursuing legal action to enforce the insurance requirements. In no event shall County permit a contractor to work under a Subcontract when the County is aware that the contractor is not in compliance with the insurance requirements. As used in this section, a "first tier" contractor is a contractor with which the county directly enters into a contract. It does not include a subcontractor with which the contractor enters into a contract.

B. TYPES AND AMOUNTS.

WORKERS' COMPENSATION & EMPLOYERS' LIABILITY
All employers, including Contractor, that employ subject workers, as defined in ORS 656.027, shall comply with ORS 656.017 and shall provide workers' compensation insurance coverage for those workers, unless they meet the requirement for an exemption under ORS 656.126(2). Contractor shall require and ensure that each of its subcontractors complies with these requirements. If Contractor is a subject employer, as defined in ORS 656.023, Contractor shall also obtain employers' liability insurance coverage with limits not less than $500,000 each accident. If contractor is an employer subject to any other state's workers' compensation law, Contactor shall provide workers' compensation insurance coverage for its employees as required by applicable workers' compensation laws including employers' liability insurance coverage with limits not less than $500,000 and shall require and ensure that each of its out-of-state subcontractors complies with these requirements.

COMMERCIAL GENERAL LIABILITY:
☒ **Required** ☐ **Not required**

Commercial General Liability Insurance covering bodily injury and property damage in a form and with coverage that are satisfactory to the Agency. This insurance shall include personal and advertising injury liability, products and completed operations, contractual liability coverage for the indemnity provided under this contract, and have no limitation of coverage to designated premises, project, or operation. Coverage shall be written on an occurrence basis in an amount of not less than $1,000,000 per occurrence. Annual aggregate limit shall not be less than $2,000,000.

AUTOMOBILE LIABILITY INSURANCE:
☒ **Required** ☐ **Not required**

Automobile Liability Insurance covering Contractor's business use including coverage for all owned, non-owned, or hired vehicles with a combined single limit of not less than $1,000,000 for bodily injury and property damage. This coverage may be written in combination with the Commercial General Liability Insurance (with separate limits for Commercial General Liability and Automobile Liability). Use of personal automobile liability insurance coverage may be acceptable if evidence that the policy includes a business use endorsement is provided.

PROFESSIONAL LIABILITY:
☒ **Required** ☐ **Not required**

Professional Liability insurance covering any damages caused by an error, omission or any negligent acts related to the services to be provided under the Subcontract by the Contractor and Contractor's subcontractors, agents, officers or employees in an amount not less than $1,000,000 per claim. Annual aggregate limit shall not be less than $2,000,000. If coverage is on a claims made basis, then either an extended reporting period of not less than 24 months shall be included in the Professional Liability insurance coverage, or the Contractor shall provide Tail Coverage as stated below.

PHYSICAL ABUSE AND MOLESTATION INSURANCE COVERAGE:
☒ **Required** ☐ **Not required**

Abuse and Molestation Insurance in a form and with coverage that are satisfactory to the Agency covering damages arising out of actual or threatened physical abuse, mental injury, sexual molestation, negligent: hiring, employment, supervision, investigation, reporting to proper authorities, and retention of any person for whom the Contractor is responsible including but not limited to Contractor and Contractor's employees and volunteers. Policy endorsement's definition of an insured shall include the Contractor, and the Contractor's employees and volunteers. Coverage shall be written on an occurrence basis in an amount of not less than $1,000,000 per occurrence. Any annual aggregate limit shall not be less than $3,000,000. Coverage can be provided by a separate policy or as an endorsement to the commercial general liability or professional liability policies. The limits shall be exclusive to this required coverage. Incidents related to or arising out of physical abuse, mental injury, or sexual molestation, whether committed by one or more individuals, and irrespective of the number of incidents or injuries or the time period or area over which the incidents or injuries occur, shall be treated as a separate occurrence for each victim. Coverage shall include the cost of defense and the cost of defense shall be provided outside the coverage limit.

EXCESS/UMBRELLA INSURANCE:
A combination of primary and excess/umbrella insurance may be used to meet the required limits of insurance.

ADDITIONAL COVERAGE REQUIREMENTS:
Contractor's insurance shall be primary and non-contributory with any other insurance. Contractor shall pay for all deductibles, self-insured retention and self-insurance, if any.

ADDITIONAL INSURED:
All liability insurance, except for Workers' Compensation, Professional Liability, and Network Security and Privacy Liability (if applicable), required under the Subcontract must include an additional insured endorsement specifying the State of Oregon, its officers, employees and agents as Additional Insureds, including additional insured status with respect to liability arising out of ongoing operations and completed operations, but only with respect to Contractor's activities to be performed under the Subcontract. Coverage shall be primary and non-contributory with any other insurance and self-insurance. The Additional Insured endorsement with respect to liability arising out of Contractor's ongoing operations must be on ISO Form CG 20 10 07 04 or equivalent and the Additional Insured endorsement with respect to completed operations must be on ISO form CG 20 37 04 or equivalent.

WAIVER OF SUBROGATION:
Contractor shall waive rights of subrogation which Contractor or any insurer of Contractor may acquire against the Agency or State of Oregon by virtue of the payment of any loss. Contractor will obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the Agency has received a waiver of subrogation endorsement from the Contractor or the Contractor's insurer(s).

TAIL COVERAGE:
If any of the required insurance is on a claims made basis and does not include an extended reporting period of at least 24 months, Contractor shall maintain either tail coverage or continuous claims made liability coverage, provided the effective date of the continuous claims made coverage is on or before the effective date of the Subcontract, for a minimum of 24 months following the later of (i) Contractor's completion and County's acceptance of all Services required under the Subcontract, or, (ii) County or Contractor termination of the Subcontract or, iii) The expiration of all warranty periods provided under the Subcontract.

CERTIFICATE(S) AND PROOF OF INSURANCE:
County shall obtain from the Contractor a Certificate(s) of Insurance for all required insurance before delivering any Goods and performing any Services required under this Contract. The Certificate(s) shall list the State of Oregon, its officers, employees and agents as a Certificate holder and as an endorsed Additional Insured. The Certificate(s) shall also include all required endorsements or copies of the applicable policy language effecting coverage required by this Contract. If excess/umbrella insurance is used to meet the minimum insurance requirement, the Certificate of Insurance must include a list of all policies that fall under the excess/umbrella insurance. As proof of insurance Agency has the right to request copies of insurance policies and endorsements relating to the insurance requirements in this Contract.

NOTICE OF CHANGE OR CANCELLATION:
The Contractor or its insurer must provide at least 30 days' written notice to County before cancellation of, material change to, potential exhaustion of aggregate limits of, or non-renewal of the required insurance coverage(s).

INSURANCE REQUIREMENT REVIEW:
Contractor agrees to periodic review of insurance requirements by Agency under this agreement and to provide updated requirements as mutually agreed upon by Contractor and County.

STATE ACCEPTANCE:
All insurance providers are subject to Agency acceptance. If requested by Agency, Contractor shall provide complete copies of insurance policies, endorsements, self-insurance documents and related insurance documents to Agency's representatives responsible for verification of the insurance coverages required under this Exhibit B.

EXHIBIT C – SERVICE TRACKING IN JJIS

This Policy Statement "Service Tracking in JJIS" may be updated from time to time. County is responsible for checking OYA's Public website at http://www.jjis.state.or.us/policy/servicetracking.htm for the most current version. Below is an example of the Policy Statement current as of the date of this Agreement. Any additional forms listed within the example can be accessed by accessing the website listed above and following the associated links.

Oregon
Juvenile Justice Information System

Policy Statement

Service Tracking in JJIS

Approved: Philip Cox, Co-Chair JJIS Steering Committee	**Effective Date:**	1/16/2013
	JJIS Steering Committee Approval:	12/19/2012
	JJIS Policy & Standards Committee Approval:	8/22/2012
	Supersedes:	
REFERENCE:		

PURPOSE:	• *To provide a standard for consistency in tracking services in JJIS;* • *To provide a threshold for a view of current juvenile justice practice;* • *To provide a foundation to compare trends in key service areas over time; and* • *To establish a foundation to develop capacity to measure results based on evidence*
DEFINITIONS:	Services are classified in JJIS according to Program Type as described below. Services are organized activities or programs designed to hold youth accountable for behavior or provide treatment, skills and capacities to change behavior.

Program Type	Definition
Accountability	Services designed to provide a consequence or an accountability experience for a youth. Examples include extended detention, community service, and restitution. Includes services designed to provide alternative service coordination for accountability experiences such as Sanction Court, Peer Court and Youth Court.
Competency Development	
Educational	Elementary and secondary education programs and services designed to assist a youth in obtaining either a high school diploma or a GED.
Independent Living	Services designed to assist a youth transition into independent living.

Program Type	Definition
Skill Development – Non-Residential	Non-residential services that assist youth in changing values, attitudes and beliefs in order to demonstrate pro-social thinking and behavior and in developing life skills and competencies for pro-social thinking and behavior. Interventions in this category include Anger Management, Conflict Resolution, Effective Problem Solving, Cognitive Restructuring.
Skill Development – Residential	Residential services that assist youth in changing values, attitudes and beliefs in order to demonstrate pro-social thinking and behavior and in developing life skills and competencies for pro-social thinking and behavior. Interventions in this category include Anger Management, Conflict Resolution, Effective Problem Solving, Cognitive Restructuring.
Therapeutic Foster Care	Foster care in homes with foster parents who have been trained to provide a structured environment that supports youth's learning social and emotional skills.
Vocational	Services to teach basic vocational skills, career exploration, skills and vocational assessment, vocational training, work experience, work readiness and life skills related to maintaining employment.
Family	
Family Counseling	General family counseling services.
Family Education	Family & Parent Training and Education services. This category excludes family mental health programs and multi-dimensional family services like Family Counseling, Multi-Systemic Therapy & Functional Family Therapy.
Functional Family Therapy	Empirically based family intervention services for youth and their families, including youth with problems such as conduct disorder, violent acting-out, and substance abuse. Service is conducted both in clinic settings as an outpatient therapy and as a home-based model
Multi-Systemic Therapy	Empirically based family intervention service for youth and their families that works on multi-systems within the family and extended family structure.
Fire Setter	
Fire Setter – Non-Residential	Non-residential treatment services for youth with inappropriate or dangerous use of fire.
Fire Setter – Residential	Residential treatment services for youth with inappropriate or dangerous use of fire.

Program Type	Definition
Gang	
Gang – Non-Residential	Non-residential services designed to address juvenile gang related behavior, membership and affiliation.
Gang – Residential	Residential services designed to address juvenile gang related behavior membership and affiliation.
Mental Health	
Mental Health – Non-Residential	Non-residential and aftercare services designed to treat specific DSM-IV Mental Health diagnoses.
Mental Health – Residential	Residential services designed to treat specific DS-MIV Mental Health diagnoses.
Co-Occurring	
Co-Occurring – Non-Residential	Non-residential and aftercare services designed to treat youth with co-occurring specific DS-MIV Mental Health diagnoses and substance abuse issues.
Co-Occurring – Residential	Residential services designed to treat youth with co-occurring specific DS-MIV Mental Health diagnoses and substance abuse issues.
Sex Offender	
Sex Offender – Non-Residential	Non-residential services designed to address juvenile sex offending behavior and prevent subsequent behavior.
Sex Offender – Residential	Residential services designed to address juvenile sex offending behavior and prevent subsequent behavior.
Substance Abuse	
Substance Abuse - Non-Residential	Non-residential services designed to address juvenile substance abuse and assist youth in avoiding substance abuse and/or chemical dependency. Interventions include Drug Courts, DUII Impact Panels, Substance Abuse Education and Support Groups and Outpatient Treatment or after care.
Substance Abuse - Residential	Residential services designed to address juvenile substance abuse and assist youth in avoiding substance abuse and/or chemical dependency.

Other Youth Services	
Drug Court	Specialized courts designed to handle cases involving substance abuse where the judiciary, prosecution, defense, probation, law enforcement, mental health, social service and treatment communities work together to break the cycle of addiction. Offenders agree to take part in treatment, regular drug screenings, and regular reporting to the drug court judge.
Mentoring	Services foster a relationship over a prolonged period of time between a youth and older, caring, more experienced individuals who provide help to the younger person to support healthy development.
Other – Residential	Residential services which are unable to be categorized with any of the existing categories.
Other – Youth Services	Other services which are unable to be categorized with any of the existing categories.
Victim Related	Services other than Restitution or Community Service that assist youth in developing empathy for victims of their crimes and provide opportunities to repair harm. Interventions in this category include Victim Impact Panels, Victim Offender Mediation.
Wrap Around	Planning process designed to create individualized plans to meet the needs of children and their families by utilizing their strengths. The exact services vary and are provided through teams that link children, families and foster parents and their support networks with child welfare, health, mental health, educational and juvenile justice service providers to develop and implement comprehensive service and support plans.
Assessment	Assessments and evaluations performed to help identify the need for specialized services.
Foster Care	Foster care
Medical	Medical services such as medication management, routine physicals and dental exams, tattoo removal services and other medical care.

POLICY:

Tracking and reporting on services provided to youth by Oregon's juvenile justice system provides a view of current juvenile justice practice, creates a preliminary framework to develop means of analyzing results in the future, and moves the juvenile system toward evidence-based practices.

Tracking

Required Tracking

All youth specific competency development, treatment services, and designated youth services funded with state Prevention, Basic, and Diversion funds and all OYA paid services in the following Program Types will be tracked in JJIS:

- Competency Development
  - Educational
  - Independent Living
  - Skill Development – Non-Residential
  - Skill Development – Residential
  - Therapeutic Foster Care
  - Vocational
- Family
  - Family Counseling
  - Family Education
  - Functional Family Therapy
  - Multi-Systemic Therapy
- Fire Setter
  - Fire Setter – Non-Residential
  - Fire Setter – Residential
- Gang
  - Gang – Non-Residential
  - Gang – Residential
- Mental Health
  - Mental Health – Non- Residential
  - Mental Health – Residential
- Co-Occurring
  - Co-Occurring – Non-Residential
  - Co-Occurring – Residential
- Sex Offender

- Sex Offender – Non-Residential
- Sex Offender – Residential

- Substance Abuse
  - Substance Abuse - Non-Residential
  - Substance Abuse - Residential

- Other Youth Specific Services
  - Drug Court
  - Mentoring
  - Other Residential
  - Other Youth Services
  - Victim Related
  - Wrap Around

At a minimum, the Service Start Date, End Date and Completion Status will be tracked consistent with local policy, using at least one of three JJIS features:

- Services
- Case Plan Interventions
- Programs attached to Conditions

In the event that multiple features have been used to track the same program with overlapping dates, JJIS will create a summary Service Episode record for reporting.

Services tracked in other JJIS features, such as Population Groups, will not be recognized in reports designed to analyze service records because the data will not be standardized with appropriate reporting attributes.

Unless otherwise approved to provide a comparable data file to include with reports, only those services tracked in one of the three approved features will be recognized in statewide JJIS reports. The annual published report will include only accountability, competency development, and treatment services.

Subject to local policy, service dosage, attendance, and participation may be tracked using the Attendance Tracking feature.

Optional Tracking

Service tracking is not required for the following basic and infrastructure services, but may be tracked according to local protocol.

- Accountability services designed to provide a consequence or an accountability experience for a youth.
  - Community Service
  - Work Crews

- Restitution Programs

- Accountability services designed to provide alternative service coordination for accountability experiences
  - Sanction Court
  - Peer Court
  - Youth Court
- Basic and Intensive supervision; offense specific caseloads; intensive monitoring
- * Basic pre-adjudicatory detention, detention sanctions, extended detention, and basic shelter care

* Detention and shelter based treatment programs may be tracked as service separate from the custody episode.

Non-trackable Services

- Other Basic Services
  - Assessments and Evaluations.
  - Medical Services
  - Activity Fees
  - Clothing Vouchers
  - Education (including GED Testing and Tutoring)
  - Electronic Monitoring & Tracking
  - Medication
  - **Polygraphs
  - School Liaison Counselor
  - Service Coordination
  - Translation Services
  - Transportation & Gas Voucher
  - **UA's.

** Polygraphs and UA's results may be tracked in Conditions.

Monitoring Data Integrity

Monitor Administrative - Set Up

OYA and county juvenile departments will review the providers and programs set up in JJIS at least annually to assure proper Program Type classification, accurate visibility to users in the drop down lists, and other optional reporting attributes. OYA and counties share provider and programs and it is essential that these attributes be set up correctly in order to assure accurate reporting.

	Counties programs also have a funding reporting attribute called Report Option – which identifies how a program is funded for a particular county during a specified date range. This is the only attribute that provides the opportunity to report on programs funded with state Diversion, Basic, and Prevention dollars and must be maintained. Counties are responsible to assure their Report Options are accurate. OYA's Diversion Specialist will facilitate an annual audit of county programs in JJIS to assure consistency with the annual Diversion and Basic plans, and will provide a copy of the annual inventory to the state office responsible for administering state Prevention funds to assure consistency with the Prevention plans. JJIS Report 562 – Active Program Report Options and Visibility can be used to monitor the administrative set up for a specific office. • http://www.jjis.state.or.us/reports/details/detail00562.htm **Monitor Service Tracking** A variety of reports have been developed to monitoring tracking throughout the year. Offices will use these reports to assure that services intended to be tracked are tracked. Data provided via a data file, instead of recorded in JJIS, will be included in these reports only if the data file has been submitted to the OYA Information System Reports team prior to the scheduling of the report in the format and within the timeline established by team. JJIS Report 363 – Program History Summary Extract - can be used to monitor service tracking data entry. This data extract can be scheduled for active during a date range, started during a date range, or ended during a date range for a specific reporting category and for a specific agency. • http://www.jjis.state.or.us/reports/details/detail00363.htm **Attendance Tracking** JJIS maintains a comprehensive Attendance Tracking feature to provide a way to document youth attendance and progress in a number of defined program sessions, and can be used to document group and individual treatment sessions. Offices will implement this feature subject to local policy. Offices that implement this feature are responsible to maintain the Program Course Definitions that are required to manage its use.

PROCEDURES:	**Tracking Services**
	
	1. Determine which JJIS feature the office will use to track services:
	  ○ Services
	  ○ Case Plan Interventions

	○ Programs on Conditions 2. Determine when service will be tracked in JJIS – when service is opened, when service is closed, when case is closed. Services tracked when the case is closed might be excluded from reports. 3. Determine local protocol for who will enter the services. 4. Train staff on local policy and protocol. **Maintaining Provider/Programs in JJIS** 1. Conduct an annual inventory of Providers and Programs in JJIS. 2. Verify the program is still active for the office and other reporting attributes. 3. Submit changes to the JJIS Help Desk via the appropriate Provider/Program Request Form. Requests for new programs and requests to inactivate or remove visibility from a program must be initiated with the form. **Maintaining Attendance Tracking Course Definitions** 1. Conduct an annual inventory of active Course Definitions in JJIS. 2. Verify the course and course definitions are still active for the office. 3. Submit requests for new program course descriptions or changes to existing descriptions to the JJIS Help Desk the appropriate Provider/Program Request Form. Requests to inactivate an existing course description may be submitted by an authorized representative from your office to the JJIS Help Desk by email.
FORMS:	• OYA Provider Program and Course Definition Request Form (YA 1751) • JJIS Form 10a and 10b Instructions • JJIS Form 10a – County Provider Program Request Form (new program) • JJIS Form 10b – County Program Form (mass entry/annual review)

Oregon

Kate Brown, Governor

Oregon Youth Authority
Procurement Unit
530 Center Street NE, Suite 500
Salem, Oregon 97301
Voice: (503) 373-7330
Fax: (503) 373-7921
www.oregon.gov/OYA

Document Return Statement

October 8, 2021

Re: Contract# 14719 hereafter referred to as "Contract."

Please complete and return the following documents:

- This Document Return Statement
- Completed signature page(s)

Note: If you have any questions or concerns with the above referenced Contract, please feel free to contact Susanna Ramus, Contract Specialist at (503) 373-7330.

Please complete the following:

I Tootie Smith, Chair

(Name) (Title)

received a copy of the above referenced Contract, consisting of 26 pages between the State of Oregon, acting by and through its **Oregon Youth Authority** and **Clackamas County** by email from OYA Procurement Unit on the date listed above.

On _____, I signed the printed form of the electronically transmitted Contract without change.

_____ _____

(Authorized Signature) (Date)

Sue Hildick
Director
Public & Government Affairs 503-655-8751
2051 Kaen Road
Oregon City, OR 97045 clackamas.us

November 30, 2021

Board of County Commissioners
Clackamas County

Members of the Board:

A Board Order Terminating the Cable Television Franchise Agreements for use of the County Rights-of-Way with Reliance Connects (Cascade Access, LLC), DirectLink (Canby Telecom), ColtonTel (Colton Telephone Company), Clear Creek Communications (Clear Creek Mutual Telephone Company), and Government Camp Cable, Inc.

Purpose/Outcome	Board Order to terminate the cable television franchise agreements.
Dollar Amount and Fiscal Impact	Lost cable franchise fees for FY21-22: $42,827 Lost Public Educational and Government (PEG) channel payments for FY21-22: $6,456
Funding Source	Payments from franchisees based upon gross receipts from cable subscribers and PEG payments.
Duration	Effective: Reliance Connects: October 15, 2009 – October 15, 2021 DirectLink: August 6, 2020 – January 31, 2022 Coltontel: May 17, 2012 – December 31, 2021 Clear Creek Com.: June 21, 2012 – March 31, 2022 Government Camp Cable: April 27, 2017 – October 1, 2021
Previous Board Action/Review	The current franchise agreements were approved by the BCC as shown above as the start dates.
Strategic Plan Alignment	Building public trust through good government.
Counsel Review	This Franchise Agreement has been reviewed and approved by County Counsel on 11-2-21. JM
Procurement Review	No, because this is item is a franchise agreement.
Contact Person	Sue Hildick, Public and Government Affairs, 503-742-5900
Contract No.	N/A

BACKGROUND:
The County has Franchise Agreements for use of the County's rights-of-way to provide cable television service and communications to residents in unincorporated Clackamas County with the following cable providers: Reliance Connects (Cascade Access, LLC), DirectLink (Canby Telecom), ColtonTel (Colton Telephone Company), Clear Creek Communications (Clear Creek Mutual Telephone Company), and Government Camp Cable, Inc. All of these cable providers had been paying franchise fees to Clackamas County of 5% of gross revenues.

The Franchise Agreements also include broadcast of some or all of the following five (5) Public, Educational and Government (PEG) Access Channels: Clackamas County Government Channel, Clackamas Community College Channel, North Clackamas School District-Sabin Schellenberg Center

Channel, and the Willamette Falls Studios Channel in the service area of the cable companies. The cable companies are supporting the five Access Channels with a monthly contribution of $.80--$1.00 per cable subscriber.

Due to market forces, the above cable providers have provided notice to Clackamas County of their intention to cease cable operations. Copies of the letters provided to the County are attached. In the case of all of these providers, except Government Camp Cable, they were using a service called EZVideo to provide a traditional cable television like service delivered using an internet connection. The company that provided the EZVideo service filed for bankruptcy. As part of the bankruptcy proceeding, EZVideo was purchased from its original owners by TiVo (a provider of DVRs and streaming services). TiVo chose to substantially increase the cost of EZVideo to the four companies. Subsequently, the companies all made a determination that they could no longer even "break even" in the provision of Cable Service at affordable rates to their subscribers. Government Camp Cable similarly made the decision to cease cable services when the cost to acquire content increased at the same time as the number of cable subscribers decreased.

During this time that the cable providers have been winding down operations they have agreed to provide information to subscribers about how to find information from the PEG access centers online. Public and Government Affairs will also be advertising ways to find the Clackamas County access centers' online on the Clackamas County Government Channel's readerboard. This programming information will also be provided to the access centers to post on their channel readerboards.

One element of cable television that is not currently replicated online is the Emergency Broadcast System. This is a service that Clackamas 911, Fire Departments, law enforcement, and the National Weather Service use to get emergency information to people while watching television and listening to radio. While this service will no longer reach residents in the areas via cable television it will continue over broadcast television and radio. Residents can also sign up for emergency alerts via Everbridge reverse 911. The sign up can be found here: https://www.clackamas.us/dm/publicalerts. In the case of an emergency a user will receive alerts by email, VOIP, TTY/TDD devices, or on their cell phone.

RECOMMENDATION:
Staff respectfully recommends the Board approve the Order to Terminate Cable Television Franchise Agreements with: Reliance Connects effective October 15, 2021; DirectLink effective January 31, 2022; Coltontel effective December 31, 2021; Clear Creek Com. effective March 31, 2022; and Government Camp Cable effective October 1, 2021. County Counsel has reviewed and approved the attached Board Order.

Respectfully submitted,

Sue Hildick, Director
Public and Government Affairs

BEFORE THE BOARD OF COUNTY COMMISSIONERS
OF CLACKAMAS COUNTY, STATE OF OREGON

In the Matter of Terminating the Cable Television Franchise Agreements for use of the County Rights-of-Way with Reliance Connects (Cascade Access, LLC), DirectLink (Canby Telecom), ColtonTel (Colton Telephone Company), Clear Creek Communications (Clear Creek Mutual Telephone Company), and Government Camp Cable, Inc.

Order No. _____

This matter coming on at this time, and it appearing that Reliance Connects (Cascade Access, LLC), has been providing cable television service utilizing the County rights-of-way pursuant to Franchise Agreement, approved by the BCC on October 15, 2009, that expired on October 15, 2021 and;

It further appearing that DirectLink (Canby Telecom) has been providing cable television service utilizing the County rights-of-way pursuant to Franchise Agreement, approved by the BCC on August 6, 2020 and requests that the franchise be terminated effective January 31, 2022, and;

It further appearing that ColtonTel (Colton Telephone Company) has been providing cable television service utilizing the County rights-of-way pursuant to Franchise Agreement, approved by the BCC on May 17, 2012 and requests that the franchise be terminated effective December 31, 2021, and;

It further appearing that Clear Creek Communications (Clear Creek Mutual Telephone Company) has been providing cable television service utilizing the County rights-of-way pursuant to Franchise Agreement, approved by the BCC on June 21, 2012 and requests that the franchise be terminated effective March 31, 2022, and;

It further appearing that Government Camp Cable, Inc. has been providing cable television service utilizing the County rights-of-way pursuant to Franchise Agreement, approved by the BCC on April 27, 2017 and requests that the franchise be terminated effective October 1, 2021, and;

It further appearing that the County and the above mentioned cable providers have reviewed the market conditions and infrastructure issues leading to the companies decisions to seek to terminate their Franchise Agreements; and

It further appearing that the termination of the Franchise Agreements would be in the best interests of the citizens of the County;

NOW, THEREFORE, IT IS HEREBY ORDERED that the Franchise Agreements of the following cable providers be terminated on the dates indicated: Reliance Connects effective

BEFORE THE BOARD OF COUNTY COMMISSIONERS
OF CLACKAMAS COUNTY, STATE OF OREGON

In the Matter of Terminating the Cable Television Franchise Agreements for use of the County Rights-of-Way with Reliance Connects (Cascade Access, LLC), DirectLink (Canby Telecom), ColtonTel (Colton Telephone Company), Clear Creek Communications (Clear Creek Mutual Telephone Company), and Government Camp Cable, Inc.

Order No. _____

October 15, 2021; DirectLink effective January 31, 2022; ColtonTel effective December 31, 2021; Clear Creek Com. effective January 31, 2022; and, Government Camp Cable effective October 1, 2021.

DATED this _____ day of November, 2021.

CLACKAMAS COUNTY BOARD OF COMMISSIONERS

_____
Chair

_____
Recording Secretary

RELIANCE
CONNECTS
ROOTED HERE.
REACHING THERE.

10/6/21

Clackamas County Public and Government Affairs
Attn: Kellie Lute
2015 Kaen Road #426
Oregon City, OR 97045

Dear Kelli:

I am writing to inform you that Cascade Access, LLC d/b/a Reliance Connects will not be renewing our Cable Franchise Agreement for the use of the Clackamas County rights-of-way.

Video is an expensive service to provide. An abundance of video solutions in the market today cater to multiple preferences, and subscribers have more choices than ever to customize their entertainment experience at a price where we are no longer competitive. We do not enjoy raising customers' bills, and we do everything we can to negotiate for fair rates from content providers and technology partners. However, the changes the TV industry are facing make it extremely difficult for small companies like Reliance Connects to continue to offer video services at reasonable rates. We have seen all core product programming tier costs more than double in the last decade. Even though we pool our content negotiations with hundreds of independent providers throughout the United States, we are unable to offer the kinds of packages and programming options at affordable prices that customers want. Therefore, Reliance Connects will be discontinuing Cable services as of October 31, 2021.

Reliance Connects will continue to offer high quality broadband service to our customers within our exchange boundary. All our customers have access to broadband service, which can be used to find at transport subscription TV services. We have compiled information about a variety of popular options and are ready to help customer navigate all the options. Many include customizable live cable and/or local channel packages at affordable prices with many of the same features and content customers have grown to love. The majority of these services work over the Internet on the same device(s) our customers use now to access Cable/EZVideo. Visit **www.relianceconnects.com/streaming** to learn more about these options.

It has been a pleasure working with Clackamas County and we look forward to future projects.

Sincerely,

Matt Day

PO Box 189
Estacada, OR 97023

Phone: 503.630.4202
Fax: 503.630.8934

R&H REIF & HUNSAKER PC

273 NORTH GRANT STREET · CANBY, OR 97013
(O) 503-266-3456 (F) 503-266-8555
VISIT US ONLINE AT CANBYLAW.COM

James M. Hunsaker
jim@canbylaw.com
* licensed in Oregon, Washington, and Colorado

August 24, 2021

Administrative Services Manager
Public and Government Affairs Department
2051 Kaen Road, 4th Floor, Suite 426
Oregon City, OR 97045

SENT CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Re: Cable Television Franchise Agreement
Clackamas County – Canby Telcom/DirectLink
July 2020 ("Franchise Agreement")

To whom it may concern:

We represent DirectLink on various matters. Please be advised that, as of January 31, 2022, Canby Telcom d/b/a DirectLink will cease offering video services (EZVideo and IPTV). As such, DirectLink will no longer be a Cable Operator, offer Cable Service, or operate a Cable System (each as defined in the Franchise Agreement).

While this was a difficult decision, it is the direct result of the bankruptcy of our video service provider. DirectLink has announced this change to its members and is actively assisting them in transitioning from EZVideo and IPTV to a replacement video service provider.

DirectLink will continue to offer telephone and internet services.

If you have any questions or concerns about these matters, please let me know.

Thank you.

Sincerely,

James M. Hunsaker

cc: Paul Hauer, DirectLink (via e-mail)
Kellie Lute, Clackamas County (via e-mail)
Jeff Munns, Clackamas County (via e-mail)

STAYTON LAW

Jennifer L. Tiger
Attorney at Law

582 E Washington St
PO Box 248
Stayton, OR 97383-0248

503.769.7741

jennifer@staytonlaw.com

www.staytonlaw.com

Admitted in OR and WA

August 30, 2021

CERTIFIED MAIL RETURN RECEIPT REQUESTED
AND REGULAR MAIL

Cable Communications Manager
Clackamas County
2051 Kaen Road
Oregon City, OR 97045

RE: Notice of Termination of Operation of Cable System

This office represents Colton Telephone Company, an Oregon cooperative corporation doing business as ColtonTel, PO Box 68, Colton, OR 97017 ("ColtonTel").

As you may know, the DirectLink Board of Directors has voted to discontinue offering both its IPTV and EZVideo services to its members as of January 31, 2022. As DirectLink is ColtonTel's content provider, this letter is to formally and officially notify you that Colton will be unable to continue providing video service to its customers and will cease its video operations effective December 31, 2021.

The Cable Television Franchise Agreement dated May 2012, by and between the County and ColtonTel requires the parties to meet within 30 days to discuss ColtonTel's plan and its effect on customers and County rights of way. Please contact Geri Fraijo, General Manager, at 503-824-3211 at your earliest convenience to schedule a time at which to meet to discuss this matter.

Thank you for your courtesy and cooperation in this matter. Please do not hesitate to contact me if you have any questions or desire further information.

Very truly yours,

Jennifer L. Tiger

cc: Geri Fraijo, ColtonTel

Clear Creek
Communications

18238 S. Fischers Mill Road
Oregon City, OR 97045-9696
Phone: (503) 631.2101
Fax: (503) 631.2098
www.ccmtc.com

10/11/2021

Clackamas County Public and Government Affairs
Attn: Kellie Lute
2015 Kaen Road #426
Oregon City, OR 97045

Dear Kelli,

I am writing to inform you that Clear Creek Mutual Telephone, d/b/a Clear Creek Communications, will be sunsetting its Cable TV service as of March 31, 2021.

This decision was not an easy one to make but has been a topic in board meetings for years. Below are some the factors that drove the decision process.

- Industry Broadcast retransmission fees have increased from 2.4 billion in 2012 to 11.8 billion in 2022. That's nearly a 400% increase in 10 years. (In comparison, the US inflation for the same period was just 25%).
- Current surveys indicate that 27% of US households plan to cut cable TV in 2021, and 40% will drop service by 2025.
- 55% of Pay-TV households consider live sports important in their decision in service choice.
- 39% are now watching sports via OTT.
- 78% of US households subscribe to at least one OTT service (Netflix, Amazon Prime, Hulu, Disney+, HBO Max, etc.), 61% subscribe to 2 or more.

Clear Creek and other neighboring telcos attempted to mitigate the negative financial impacts by consolidating headends and pooling recourses to form Oregon Cable Group. This worked to stave off heavy investments but, as consumers continue to move to over-the-top programming, the costs became too much.

With the Oregon Cable Group shutting down the "super head-end", Clear Creek is faced with no choice but to follow. This has been talked about for some time and this is certainly sooner than anyone would have anticipated. The video industry was thrust into overdrive in the past 18-24 months with COVID. Not that it was not in motion, but COVID certainly accelerated the pace.

Over the next 6 months Clear Creek will be working to educate our members who subscribe to CATV on over-the top streaming by doing the following:

- Hosted in-person Q&A sessions at the office
- In-home assistance turnup streaming devices
- Website page dedicated to streaming options **ccmct.com/streaming**
- Dish Satellite for those who want that traditional CATV experience (there will be some)

Clear Creek will continue to offer high quality broadband and voice service to our members within our exchange boundaries. All of our customers have access to broadband which can be used to find video services that they have today. In many ways, we see this as Clear Creek getting back to what we do best and that is connecting members in the Redland community to the world.

It has been a pleasure working with Clackamas County and we look forward to future projects.

Sincerely,

Jay Henke
President

MT. HOOD MANAGEMENT LLC PO BOX 70 GOVERNMENT CAMP OR 97028

October 25, 2021

Administrative Services Manager
Public and Government Affairs Department
20512 Kean Road, 4th Floor, Suite 426
Oregon City, OR 97045

Re: Cable Franchise Agreement - Termination

To Whom It May Concern:

I am writing you to inform you that Government Camp Communications made the difficult decision to cease billing the 18 remaining customers we had on our cable system and to terminate the services offered over coax cable on January 1st, 2021. We made this decision for the following reasons:

1) The ability to deliver content, as cable content providers moved satellites, became untenable. Given our limited line of site, the new satellite feeds became unreachable.

2) The limited content we could provide became too cost prohibitive for us and our customers.

3) Our customers migration from coax cable to high-speed internet and the platforms video providers offer, decimated our customer base by over 80%.

As a result of these market conditions, effective October 1st, 2021, Government Camp Communications will no longer be a cable operator, offer cable service, or operate a cable system, (each as defined in the Franchise Agreement).

If you have any questions, comments, or concerns regarding this Letter of Termination, please contact me directly. It has been a pleasure to work with the county, specifically Kellie Lute, and we look forward to continuing our relationship with the Technology Services Department.

Regards,

Brett Fischer
General Manager
Mt. Hood Management
DBA Government Camp Communications

Daniel Nibouar
Interim Director

Disaster Management
1710 Red Soils Ct., Ste. 225
Oregon City, OR 97045

T 503-655-8378
clackamas.us

December 2, 2021

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of Amendment #3 to the Personal Services Agreement with Advantage Nurse Staffing of Oregon, Inc. to Provide On-Call Temporary Medical Staffing Services to Respond to the COVID-19 Pandemic

Purpose/Outcome	Extend the term and add funds.
Dollar Amount and Fiscal Impact	Increase by $5,100,000. Bringing total contract value to $7,100,000.
Funding Source	Reimbursement for these expenses are covered by Public Health ARPA and FEMA funds
Duration	Amendment #3 is effective upon signature and expires on 12/31/2022
Previous Board Action/Review	The Board previously approved this Agreement on January 5, 2021, Agenda item 010521-VI. 1, March 23, 2021, and June 22, 2021.
Strategic Plan Alignment	1. Sustaining Public Health and Wellness. 2. Keep vulnerable residents safe and healthy.
Counsel Review	Counsel approval 11/16/21 by AN
Procurement Review	Was the item process through Procurement? ☒ yes no
Contact Person	Philip Mason-Joyner , 503-742-5956 or Jeanne Weber x5350
Contract No.	Cobblestone #3607-03 – H3S #9829

Background:
In order for the County to respond the COVID-19 pandemic, the Public Health and the Health Centers Divisions of Health Housing and Human Services needed to quickly contract with firms to provide registered nurses to conduct contact tracing and to potentially provide clinical services. The original contracts were authorized under the emergency declaration issued by the Board. As the COVID-19 pandemic has not subsided, the department needed to establish longer-term contracts for services to ensurecontinuity of services and allow for rapid expansion of services as needed. The department worked with Procurement to issue a Request for Proposals Process to retain three firms for on-call services. Reimbursement for these expenses are covered by ARPA and FEMA funds.

Due to nationwide health care staffing shortages, registered nurses and certified medical assistants may be unavailable because they are being offered higher compensation at other organizations. To ensure availability of temporary medical staffing services provided under this Contract, it is necessary for the County to make allowances for increased rates for temporary medical staffing services ("Surge Rates")

Amendment #3 extends the term and adds $5,100,000 to the Agreement. The Amendment is effective upon signature and terminates on December 31, 2022.

Procurement Process:
On September 30, 2020, Procurement published a RFP #2020-80 for Temporary Medical Staffing Services in accordance with LCRB C-047-0260. Proposals were received from thirty (30) firms. An evaluation team with representatives from Public Health and Health Centers evaluated the proposals and recommended an award of three (3) contracts to the highest scoring firms. The recommendation to awardto three firms was based on the need to have sufficient access to nurses and certified medical assistants to respond to the COVID-19 pandemic. The Notice of Intent to Award was issued on December 1, 2020 andno protests were received.

Recommendation:
Staff respectfully recommends that the Board approve and execute the Advantage Nurse Staffing of Oregon,Inc. Amendment #03 for On-Call Temporary Medical Staffing Services.

Sincerely,

Daniel Nibouar
Interim Director

AMENDMENT #3
TO THE CONTRACT DOCUMENTS WITH ADVANTAGE NURSE STAFFING OF OREGON, INC. FOR TEMPORARY NURSE STAFFING.
Cobblestone Contract #3607 – H3S Contract #9829

This Amendment #3 is entered into between **Advantage Nurse Staffing of Oregon, Inc.** ("Contractor") and Clackamas County ("County") and shall become part of the Contract documents entered into between both parties on **December 29, 2020** ("Contract").

The Purpose of this Amendment #3 is to make the following changes to the Contract:

1. ARTICLE I, Section 1 **Effective Date and Duration.** is hereby amendment as follows:

   By execution of this Amendment #3, County is hereby exercising the first of four (4) optional one-year renewals. The Contract expiration date is hereby changed from December 31, 2021 to **December 31, 2022**.

2. ARTICLE I, Section 3. **Consideration** is hereby amended as follows:

   County is authorizing an additional Five Million One Hundred Thousand Dollars ($5,100,000.00) as compensation for Contractor to continue to perform the Work under the Contract. Following execution of this Amendment #3, the total not to exceed amount authorized under the Contract is Seven Million One Hundred Thousand Dollars ($7,100,000.00).

ORIGINAL CONTRACT	**$ 1,000,000.00**
AMENDMENT #1	**$ 1,000,000.00**
AMENDMENT #2	**Revised Exhibit A**
AMENDMENT #3	**$ 5,100,000.00**
TOTAL AMENDED CONTRACT	**$ 7,100,000.00**

3. Exhibit A **Scope of Work** is replaced in its entirety with the attached Exhibit A:

Except as expressly amended above, all other terms and conditions of the Contract shall remain in full force and effect. By signature below, the parties agree to this Amendment #3, effective upon the date of the last signature below.

Signatures on next page

ADVANTAGE NURSE STAFFING OF OREGON, INC.

Richard B. Evans Digitally signed by Richard B. Evans DN: cn=Richard B. Evans, o=Advantage Nurse Staffing, ou, email=rick@advantagenursestaffing.com, c=US Date: 2021.11.18 16:21:05 -08'00'

Richard B. Evans, VP/COO

Date

641460-88 / DBC Oregon
Oregon Business Registry

503-432-1383
Phone

CLACKAMAS COUNTY

Commissioner: Tootie Smith, Chair
Commissioner: Sonya Fischer
Commissioner: Paul Savas
Commissioner: Martha Schrader
Commissioner: Mark Shull

Board Chair

Date

Recording Secretary

Approved as to Form

11/22/2021

County Counsel

EXHIBIT A
PERSONAL SERVICES CONTRACT
SCOPE OF WORK

Contractor to provide Oregon licensed registered nurses and certified medical assistants on an on-call basis. All registered nurses and certified medical assistants shall be employees of Contractor and covered under Contractor's insurance (as required in Article II, Section 9 above). Services shall be provided in accordance with the Scope of Work outlined in Exhibit D (RFP#2020-80 Temporary Medical Staffing Services) and Exhibit E (Contractor's proposal to RFP #2020-80 Temporary Medical Staffing Services).

Hourly Rates:
Due to nationwide staffing shortages, registered nurses and certified medical assistants may be unavailable because they are being offered higher rates at other organizations. To ensure availability of temporary medical staffing services provided under this Contract, County may, in its sole administrative discretion, authorize Contractor to charge increased rates for temporary medical staffing services ("Surge Rates") as set forth in the table below. If County authorizes Surge Rates, it will indicate the Surge Rate when it issues a Task Order for the Work. County will provide Contractor two week's written notice when electing to change between standard rates and Surge Rates for current temporary staff.

	All Shifts Standard Rates	All Shifts Surge Rates
Certified Medical Assistant	$34.00	$47.00
Certified Medical Assistant Lead	$37.00	$54.00
LPN	$53.00	$70.00
RN Tracers Remote	$72.00	$99.00
RN Tracer SME	$74.00	$104.00
Supervisor/Lead RN	$83.50	$111.00
RN Vaccinators	$78.00	$117.00
RN COVID Testing	$80.00	$136.00

Overtime (over 40 hours per week) will be billed at the standard of time and one-half.

Holiday pay will be billed at the standard of time and one-half for all hours worked on the following holidays:

New Year's Day; Martin Luther King, Jr Day; President's Day; Memorial Day, Juneteenth Day, Independence Day; Labor Day; Veteran's Day, Thanksgiving Day, Christmas Day"

This Contract is on an "on-call" or "as-needed basis" for Work.

When the County wishes Contractor to perform the Work, the County will submit an official County Task Order form (found at: https://www.clackamas.us/finance/terms.html) detailing the scope of Work, the entity on whose behalf the Work will be performed, and the total compensation, pursuant to the fee schedule set forth in this Contract. Contractor may not perform Work until the County Task Order form has been executed by the parties. In the event a project authorized under the County Task Order extends beyond the expiration of this Contract, the County Task Order shall remain in effect under the terms of this Contract until the completion or expiration of the authorized task.

No task order shall modify or amend the terms and conditions of this Contract.

The County Contract administrator for this Contract is the County Procurement and Contract Services Division. For each authorized Task Order, a project specific department representative shall be identified for coordination of the work.

Daniel Nibouar
Interim Director

Disaster Management
1710 Red Soils Ct., Ste. 225
Oregon City, OR 97045

T 503-655-8378
clackamas.us

December 2, 2021

Board of County Commissioners
Clackamas County

Members of the Board:

Approval to apply for FEMA Flood Mitigation Assistance Program (FMA) funds to Acquire and demolish a Severe Repetitive Loss (SRL) residential property.

Purpose/Outcome	Disaster Management requests approval to apply for FEMA FMA funds to buyout a flood-prone property, demolish and remove all improvements, and return the property to open space, with 100% of eligible costs covered by the FEMA grant.
Dollar Amount and Fiscal Impact	This residential property at 9490 SE Wichita Avenue along Johnson Creek has flooded the prior owner four times (2003, 2007, 2009 and 2015) in the last 18 years and is listed in a National Flood Insurance Program (NFIP) database as an SRL property and therefore qualifies for 100% costs coverage under the FMA grant. Project Total $543,391, with 100% FMA coverage for SRL properties
Funding Source	General funds will initially be used with 100% reimbursement submitted monthly
Duration	Grant performance period is three years
Previous Board Action/Review	No previous action.
Strategic Plan Alignment	1. Flood buyouts foster community resilience by avoiding future property losses, personal injury, and improving environmental health. 2. Flood buyouts improve community welfare by minimizing the need for emergency services and recovery efforts.
Counsel Review	Council review is not required until agreement is awarded
Procurement Review	Grant application. Procurement review is not required.
Contact Person	Jay Wilson, 503-723-4848

BACKGROUND: The current owner voluntarily reached out to the County in 2020 seeking sponsorship for the FEMA grant and prefers to have the property bought out rather than sell it to another buyer and perpetuate the flood losses.

RECOMMENDATION:
Staff recommends that the BCC approve that Disaster Management staff apply for the FEMA FMA grant dollars to buyout a Severe Repetitive Loss property.

Respectfully submitted,

Daniel Nibouar
Interim Director
Attachments:
Pre-application for FMA-21 grant
Grant Lifecycle Form

Hazard Mitigation Assistance
Pre-Application Form/Letter of Intent

Submitting this form ensures that your proposal is reviewed by the Mitigation Team. This document is the first step in the grant sub-application process. By submitting this form alone, it **does not guarantee funding**. To be considered for the grant funding, complete this form and submit it to shmo@mil.state.or.us. This form will also be used for the Interagency Hazard Mitigation Team (IHMT) review panel if/when activated for applicable grant program/grant round (shaded boxes to the right are for official use only for scoring/ranking pre-applications).

A. Hazard Mitigation Assistance Grant Programs

Select the grant program you are seeking funding under *(select one)*:

☐ **Pre-Disaster (Annual):** Building Resilient Infrastructure and Communities (BRIC)
☒ **Pre-Disaster (Annual):** Flood Mitigation Assistance (FMA)
☐ **Post-Disaster:** Hazard Mitigation Grant Program (HMGP): Click here to enter text.
☐ **Post-Disaster:** Hazard Mitigation Grant Program (HMGP) Post Fire (PF): Click here to enter text.

B. Activity Type

Select the applicable activity type you are pursuing *(select all that apply)*:

BRIC
- ☐ Capability- and Capacity-Building
  - ☐ Project Scoping
  - ☐ Building Codes
  - ☐ Partnerships
  - ☐ Planning
- ☐ Mitigation Project
- ☐ Technical Assistance

FMA
- ☐ Project Scoping
- ☐ Community Flood Mitigation Project
- ☐ Flood Hazard Mitigation Planning
- ☒ Individual Flood Mitigation Project
- ☐ Technical Assistance

HMGP and HMGP-PF
- ☐ Advance Assistance
- ☐ Plan
- ☐ Project
- ☐ 5 Percent Initiative

C. Subapplicant Information

1. County or Tribal Land your entity is based in: Clackamas County

2. Select the type of entity you fall under that is seeking HMA funding *(select one):*

☐ State Government ☐ Tribal Government
☒ Local Government ☐ Private Nonprofit (PNP)
☐ Special District ☐ Other Please specify

3. Subapplicant: Clackamas County Disaster Management
Point of Contact Name and Job Title: Jay Wilson, Resilience Coordinator
Phone Number: 503-209-2812 E-mail Address: jaywilson@clackamas.us
Street Address: 1710 Red Soils Ct #225
City: Oregon City State: OR Zip: 97045

D. Mitigation Plan

1. Identify which FEMA-approved hazard mitigation plan your entity is included in below.
Plan Name: Clackamas County Multi-Jurisdictional NHMP Expiration Date: 4/11/2024

2. If this is **a proposal for a planning-related activity**, please identify Plan Type you will be pursuing funding for *(select one)*:

☐ State Hazard Mitigation Plan ☐ Tribal Hazard Mitigation Plan
☐ Local Hazard Mitigation Plan ☐ Tribal (Local) Hazard Mitigation Plan
☐ Local Multijurisdictional Hazard Mitigation Plan ☐ Tribal (Local) Multijurisdictional Hazard Mitigation Plan
☐ Never had a Hazard Mitigation Plan ☐ Other planning-related activity: Please specify

E. Proposal

Proposal Title: Property Acquisition and Structure Demolition - SRL Residential – 9490 SE Wichita Ave
Estimated Overall/Total Cost: $$543,391
Do you anticipate a non-federal cost share exceeding 25%?

☐ Yes ☒ No ☐ Unsure

If yes, please provide a brief narrative and estimated percentage your jurisdiction intends on putting forth for the local cost share/match: The County expects this SRL project to be funded 100% by federal share funds.
Estimated Local Management Cost (is up to 5% of the amount listed above): $Click here to enter text.
Brief Proposal Description: This project is for the flood acquisition of a Severe Repetitive Loss (SRL) residential property along Johnson Creek in the northern area of unincorporated Clackamas County. This property meets the FMA definition of SRL, as stated in the 2021 FMA NOFO, by having NFIP coverage and having at least four flood claims that each equal or exceed $5,000 and the cumulative amount of all claims exceeds $20,000.

F. Community Lifelines

Select all applicable community lifelines that your proposal will reduce risk to:

☐ **Safety and Security** (law enforcement/security, fire services, search and rescue, government services, and community safety)
☐ **Food, Water, Shelter** (food, water, shelter, agriculture)
☐ **Health and Medical** (medical care, patient movement, public health, fatality management, medical supply chain)
☐ **Energy** (power (grid) and fuel)
☐ **Communications** (infrastructure, alerts, warnings, and messages, 911 and dispatch, responder communications, finance)
☐ **Transportation** (highway, roadway, motor vehicle, mass transit, railway, aviation, maritime)
☐ **Hazardous Martial** (facilities, HAZMAT, pollutants, contaminants)
☒ **Not Applicable**

G. Natural Hazards

Select all applicable natural hazards that your proposal will reduce/mitigate the risk of:

☐ Coastal Erosion	☐ Heat Wave	☐ Wildfire
☐ Drought	☐ Landslide	☐ Windstorm
☐ Earthquake	☐ Tsunami	☐ Winter Storm
☒ Flood	☐ Volcano	☐ Other: Please specify

H. Climate Change

Will this proposal enhance climate change adaptation and resilience?
Climate change is defined as "Changes in average weather conditions that persist over multiple decades or longer. Climate change encompasses both increases and decreases in temperature, as well as shifts in precipitation, changing risk of certain types of severe weather events, and changes to other features of the climate system."

☒ Yes ☐ No ☐ Unsure ☐ Not Applicable

If yes, please provide brief description how your proposal will enhance climate change adaptation and resilience: By removing a severe repetitive loss property from the Johnson Creek floodplain, the 0.87 acres of this property will be restored with native species to provide riparian habitat, improved stream functions, and minimize future residential flood impacts to the creek.

I. National Floodplain Insurance Program (NFIP)

Does this proposal involve mitigating a National Floodplain Insurance Program (NFIP) property?
The National Flood Insurance Program (NFIP) aims to reduce the impact of flooding on private and public structures. It does so by encouraging communities to adopt and enforce floodplain management regulations. In exchange, flood insurance is made available to property owners and renters. These efforts help mitigate the effects of flooding on new and improved structures.

☒ Yes ☐ No ☐ Unsure ☐ Not Applicable

If yes, please provide further information regarding the property (is the property in a Special Flood Hazard Area, is it considered a Severe Repetitive Loss Property or a Repetitive Loss Property, etc.): This property is listed in the 2021 FEMA RL/SRL database as both an NFIP and FMA Severe Repetitive Loss property and is in the SFHA with much of the non-improved property inside the mapped floodway.

J. Community

Select all items listed below that are applicable to the community that the proposal will benefit:

☐ Limited water and sanitation access and affordability	☐ High unemployment and underemployment	☐ High housing cost burden and substandard housing
☐ High and/or persistent poverty	☐ Low income	☐ Limited access to health care
☐ Rural community	☐ Linguistic isolation	☐ Distressed neighborhoods
☐ Jobs lost through the energy transition	☐ Disproportionate impacts from climate	☐ All geographic areas within Tribal jurisdictions
☐ High energy cost burden and low energy access	☐ High transportation cost burden and/or low transportation access	☐ Disproportionate environmental stressor burden and high cumulative impacts
☐ Racial and ethnic segregation particularly where the segregation stems from discrimination by government entities	☒ Not Applicable	

K. Additional Information

1. Is this an infrastructure project?

Infrastructure is defined as critical physical structures, facilities, and systems that provide support to a functioning community, its population, and its economy.

☐ Yes ☒ No ☐ Unsure ☐ Not Applicable

If yes, please provide further information regarding what type of infrastructure: Click here to enter text.

2. Does this project incorporate nature-based solutions?

Nature-based solutions are sustainable planning, design, environmental management, and engineering practices that weave natural features or processes into the built environment to promote adaptation and resilience. Such solutions enlist natural features and processes in efforts to combat climate change, reduce flood risks, improve water quality, protect coastal property, restore and protect wetlands, stabilize shorelines, reduce urban heat, add recreational space, and more.

☒ Yes ☐ No ☐ Unsure ☐ Not Applicable

If yes, please describe how it will incorporate nature-based solutions: The Johnson Creek Watershed Council is interested in using this site for immediate and long-term floodplain and bank restoration opportunities.

3. Does your entity have Building Code Effectiveness Grading Schedule (BCEGS) Rating of 1 to 5?

The Building Code Effectiveness Grading Schedule (BCEGS®) assesses the building codes in effect in a particular community and how the community enforces its building codes, with special emphasis on mitigation of losses from natural hazards. For more information regarding this question, please go to https://www.isomitigation.com/bcegs/.

☒ Yes ☐ No ☐ Unsure ☐ Not Applicable

If yes, please provide more information regarding your rating: The County has a 2020 score of 2.

4. Is this proposal from a previous FEMA HMA advance assistance or project scoping award, High Hazard Potential Dams (HHPD) award, or DHS Cybersecurity and Infrastructure Security Agency's (CISA) Regional Resiliency Assessment Program (RRAP), or a previous recipient of BRIC non-financial Direct Technical Assistance?

☐ Yes ☒ No ☐ Unsure ☐ Not Applicable

If yes, please identify which award and brief description: Click here to enter text.

5. Does this proposal increase resilience and reduce risk of injuries, loss of life, and damage and destruction of property, including critical services, and facilities?

☒ Yes ☐ No ☐ Unsure ☐ Not Applicable

If yes, please briefly describe how the project will effectively reduce risk and increase resilience, realize benefits, and leverage innovation. Potential benefits could include how this project will address inequities and provide the greatest support to those with greatest need: The acquisition and removal of the residential improvements that have experienced multiple flood losses will minimize the potential loss of life and property damage from future floods that are expected to increase in frequency and severity due to climate change.

6. Will this proposal utilize innovative techniques to facilitate implementation?

☒ Yes ☐ No ☐ Unsure ☐ Not Applicable

If yes, please provide brief description on how you intend to implement this proposal: Demolition of the SRL residence will include deconstruction practices to salvage any reusable building materials, such as lumber and fixtures, from this 1930s era single family home.

7. Will this proposal include an outreach strategy?

☐ Yes ☒ No ☐ Unsure ☐ Not Applicable

If yes, please provide brief description how your proposal will enhance climate change adaptation and resilience: Click here to enter text.

8. Will your entity be incorporating any partnerships (e.g., state, tribal, private, local community, etc.) that will ensure the proposal meets community needs, including those of disadvantaged populations?

☒ Yes ☐ No ☐ Unsure ☐ Not Applicable

If yes, please provide brief description how your proposal will incorporate partnerships and what is the anticipated outcome of those partnerships (e.g., leveraging resources such as financial, material, and educational resources, coordinating multi-jurisdictional projects, heightened focus on equity related issues, etc.): We will partner with the Johnson Creek Watershed Council for long-term site restoration and maintenance as open space in the floodplain.

****

(For official use only)

Total Pre-application Score:

Financial Assistance Application Lifecycle Form

Use this form to track your potential award from conception to submission.
Sections of this form are designed to be completed in collaboration between department program and fiscal staff.

**** CONCEPTION *****

Section I: Funding Opportunity Information - To be completed by Requester

Award type: ☐ Direct Appropriation (no application) ☑ Subrecipient Award ☐ Direct Award

Lead Department & Fund: Disaster Management

Award Renewal? ☐ Yes ☑ No

If renewal, complete sections 1, 2, & 4 only. If Direct Appropriation, complete page 1 and Dept/Finance signatures only.

If Disaster or Emergency Relief Funding, EOC will need to approve prior to being sent to the BCC

Name of Funding Opportunity: 2021 Flood Mitigation Assistance

Funding Source: Federal ☑ State ☐ Local ☐

Requestor Information (Name of staff person initiating form): Jay Wilson

Requestor Contact Information: jaywilson@clackamas.us

Department Fiscal Representative: Daniel Nibouar

Program Name and prior project # (please specify): Hazard Mitigatrion

Brief Description of Project:

This project is for the flood acquisition of a Severe Repetitive Loss (SRL) residential property along Johnson Creek in the northern area of unincorporated Clackamas County. This property meets the FMA definition of SRL, as stated in the 2021 FMA NOFO, by having NFIP coverage and having at least four flood claims that each equal or exceed $5,000 and the cumulative amount of all claims exceeds $20,000. Total project cost is $543,391.

Name of Funding Agency: U.S. Dept. of Homeland Security, Federal Emergency Management Agency

Agency's Web Address for funding agency Guidelines and Contact Information:

Oregon Emergency Management Hazard Mitigation Assistance https://www.oregon.gov/oem/emresources/grants/pages/hma.aspx Contact: Anna Feigum, State Hazard Mitigation Officer - anna.r.feigum@mil.state.or.us 503-378-2260

OR

Application Packet Attached: ☑ Yes ☐ No

Completed By: Jay Wilson 11/23/21 (Date)

**** NOW READY FOR SUBMISSION TO DEPARTMENT FISCAL REPRESENTATIVE *****

Section II: Funding Opportunity Information - To be completed by Department Fiscal Rep

Competitive Application ☑ Non-Competing Application ☐ Other ☐

CFDA(s), if applicable:		Funding Agency Award Notification Date:	
Announcement Date:	9/25/21	Announcement/Opportunity #:	FY21 FMA NOFO
Grant Category/Title:	Hazard Mitigation	Max Award Value:	~~N/A~~ $543,391.00
Allows Indirect/Rate:	5.00%	Match Requirement:	No match
Application Deadline:	1/17/2022	Other Deadlines:	
Award Start Date:	TBD	Other Deadline Description:	
Award End Date:	TBD		
Completed By:	36 months after award date	Program Income Requirement:	
Pre-Application Meeting Schedule:			

Additional funding sources available to fund this program? Please describe: N/A

How much General Fund will be used to cover costs in this program, including indirect expenses? General funds will be used initially with 100% reimbursement submitted monthly

How much Fund Balance will be used to cover costs in this program, including indirect expenses? ~~N/A~~ This will be a project for next fiscal year and will be included in the budget request for next year.

Section III: Funding Opportunity Information - **To be completed at Pre-Application Meeting by Dept Program and Fiscal Staff**

Mission/Purpose:

1. How does the grant/funding opportunity support the Department and/or Division's Mission/Purpose/Goals?

Using the Flood Mitigation Assistance (FMA) program to acquire flood prone residential properites reduces or eliminates the risk of repetitive flood damage to buildings and structures insured under the National Flood Insurance Program (NFIP).This project also supports the County's Performance Clackamas goals to "Ensure safe, healthy and secure communities."

2. What, if any, are the community partners who might be better suited to perform this work?

Hazard mitigation is primarily managed in the Department of Disaster Management though FEMA's Hazard Mitigation Assistance programs.

3. What are the objectives of this funding opportunity? How will we meet these objectives?

Hazard mitigation is any sustainable action that reduces or eliminates long-term risk to people and property from future disasters. Hazard mitigation includes long-term solutions that reduce the impact of disasters in the future.

4. Does the grant/financial assistance fund an existing program? If yes, which program? If no, what is the purpose of the program?

This 2021 FMA grant proposal funds a project that is part of the County's Hazard Mitigation program.

Organizational Capacity:

1. Does the organization have adequate and qualified staff? If no, can staff be hired within the grant/financial assistance funding opportunity timeframe?

Disaster Management has Mitigation Program staff to administer the grant and provide necessary coordination with project partners, as well as community education follow up.

2. Are there partnership efforts required? If yes, who are we partnering with and what are their roles and responsibilities?

Disaster Management will acquire the property to be converted into open space and anticipates support from County Parks for initial vegetation management and long-term support from community partners like the Johnson

3.If this is a pilot project, what is the plan for sunsetting the project and/or staff if it does not continue (e.g. making staff positions temporary or limited duration, etc.)?

This is not a pilot project.

4. If funded, would this grant/financial assistance create a new program, does the department intend for the program to continue after initial funding is exhausted? If yes, how will the department ensure funding (e.g. request new funding during the budget process, supplanted by a different program, etc.)?

The funding is to implement a flood mitigation project as part of the County's Hazard Mitigation program.

Collaboration

1. List County departments that will collaborate on this award, if any.

Limited collaboration from County Parks for initial vegetation management.

Reporting Requirements

1. What are the program reporting requirements for this grant/funding opportunity?

Disaster Management and Finance will provide quarterly reports to Oregon Emergency management during the three year performance period for project installation and verify project service every three years.

2. How will performance be evaluated? Are we using existing data sources? If yes, what are they and where are they housed? If not, is it feasible to develop a data source within the grant timeframe?

The Resilience Coordinator will monitor project progress and contract with DTD for demolition management services during the duration of the project performance period.

3. What are the fiscal reporting requirements for this funding?

Disaster Management and Finance will provide quarterly reports to Oregon Emergenecy management during the three year performance period for fiscal accountability and verify project service every three years.

Fiscal

1. Will we realize more benefit than this financial assistance will cost to administer?

According to the required FEMA Benefit-Cost Analysis as part of the grant application, this project has a benefit to cost ratio of 4.5 to 1, which means for every dollar spent, four and a half dollars will be saved from flood mitigation.

2. Are other revenue sources required, available or will be used to fund the program? Have they already been secured? Please name other sources, including General Fund or Fund Balance and amounts.

The Flood Mitigation Assistance program will cover all eligible project costs.
General fund will be used to cover cost with 100% reimbursement from this grant. Reimbursement requests will be completed monthly.

3. For applications with a match requirement, how much is required (in dollars) and what type of funding will be used to meet it (CGF, In-kind, Local Grant, etc.)?

Because this property is determined to be a Severe Repetitive Loss flood-prone residential property, it is eligible for 100% cost coverage with no local match required.

4. Does this grant/financial assistance cover indirect costs? If yes, is there a rate cap? If no, can additional funds be obtained to support indirect expenses and what are those sources?

This is one-time funding for this mitigation project and it does not fund the County's Hazard Mitigation program.

Program Approval:

Jay Wilson		Jay Wilson
Name (Typed/Printed)	Date	Signature

***** NOW READY FOR PROGRAM MANAGER SUBMISSION TO DIVISION DIRECTOR*****

*****ATTACH ANY CERTIFICATIONS REQUIRED BY THE FUNDING AGENCY. COUNTY FINANCE OR ADMIN WILL SIGN.*****

Section IV: Approvals

DIVISION DIRECTOR (or designee, if applicable)		
Name (Typed/Printed)	Date	Signature

DEPARTMENT DIRECTOR (or designee, if applicable)		
Daniel Nibouar	**11/23/2021**	David V. Nibouar
Name (Typed/Printed)	Date	Signature

FINANCE ADMINISTRATION		
		Elizabeth Comfort
Name (Typed/Printed)	Date	Signature

EOC COMMAND APPROVAL ***(DISASTER OR EMERGENCY RELIEF APPLICATIONS ONLY)***		
Name (Typed/Printed)	Date	Signature

Section V: Board of County Commissioners/County Administration

(Required for all grant applications. If your grant is awarded, all grant ***awards*** *must be approved by the Board on their weekly consent agenda regardless of amount per local budget law 294.338.)*

For applications less than $150,000:

COUNTY ADMINISTRATOR	Approved: ☐	Denied: ☐
Name (Typed/Printed)	Date	Signature

For applications greater than $150,000 or which otherwise require BCC approval:

BCC Agenda item #: _____ Date: _____

OR

Policy Session Date: 11/30/2021

County Administration Attestation

County Administration: re-route to department contact when fully approved.
Department: keep original with your grant file.

Evelyn Minor-Lawrence
Director

DEPARTMENT OF HUMAN RESOURCES

PUBLIC SERVICES BUILDING
2051 Kaen Road | Oregon City, OR 97045

December 2, 2021

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of 2021 Agreements with Providence Health Plan for
Administrative Services for Clackamas County's Self-Funded Medical Benefits

Purpose/Outcomes	Approval of the Clackamas County Providence Health Medical Benefit Plan Administrative Services Agreement for 2021 and five Summary Plan Descriptions for the 2021 plan year.
Dollar Amount and Fiscal Impact	The estimated fiscal impact for the 2021 plan year is: $25,103,497.44
Funding Source	Department, employee, and retiree contributions
Duration	Effective January 1, 2021 – December 31, 2021
Previous Board Action	Initially presented to the Board of County Commissioners during the October 6, 2020 Policy Session as part of the 2021 benefit renewals update. These particular documents were presented to the Board of County Commissioners at the November 9, 2021 Issues Session.
County Counsel Review	This Administrative Services Agreement and the five summary plan descriptions have been reviewed and approved by County Counsel on August 23, 2021.
Strategic Plan Alignment	1. This project provides cost-effective, responsive and comprehensive medical plan benefits to Clackamas County and Housing Authority plan employees, retirees and COBRA participants. 2. This project directly supports Human Resource's Strategic Result #5 to align wellness programs with workforce needs.
Contact Person	Kristi Durham, Human Resources, 503.742.5470

BACKGROUND:
At the Policy Session on October 6, 2020, the Board of County Commissioners approved the 2021 benefit plan renewals. Due to 2021 legislative and out-of-area provider network changes, the 2021 Providence Administrative Services Agreement (ASA) and Summary Plan Descriptions (SPDs) were not presented to Clackamas County for review until July 2021. After undergoing review, changes and final approval by all contractual parties, the ASA and SPDs were presented to the Board of County Commissioners at the November 9, 2021 Issues Session. The 2021 Providence ASA and SPDs require the board's approval and signature.

County Counsel has reviewed and approved the plan agreement and descriptions.

RECOMMENDATION:
Staff recommends the Board approve the 2021 Administrative Services Agreement and Summary Plan Descriptions from Providence Health Plan.

Sincerely,

Kristi Durham, Benefits Manager
Department of Human Resources

THIS AMENDMENT NO. 6 TO THE ADMINISTRATIVE SERVICES AGREEMENT (this "Amendment") is entered into as of January 1, 2021, by and between Clackamas County ("Plan Sponsor") and Providence Health Plan ("Providence"). Plan Sponsor and Providence are sometimes referred to in this Amendment as a "Party" or, collectively, as the "Parties."

RECITALS

A. Plan Sponsor and Providence entered into that certain Administrative Services Agreement dated on or around January 1, 2015 ("Services Agreement").

B. The Parties wish to amend the Services Agreement as set forth herein.

AMENDMENT

The Parties hereby agree as follows:

1. **Section 6.1.** The following provision in Section 6.1 (Medical Management Services) is amended and restated in its entirety as follows, effective June 1, 2021:

   "Clinical Claims Audit. *****

   For high dollar claims (those that exceed $100,000 in payable charges outside of a DRG payment method), we will refer the claim to our subcontractor who will perform an in-depth forensic clinical review of the claim to determine the appropriateness of the billed charges in accordance with the benefit provisions of this Plan. If any savings are realized through this external claim review process, the subcontractor's fee for this service is: 20% for negotiations and 30% for audits, which shall be calculated as a percentage of savings achieved. There is no charge for this service if no savings are realized by the Plan. (Note: Effective June 1, 2021, this high dollar clinical claim review service will not apply to any national wrap network claims.)"

2. **Exhibit B.** Exhibit B (Service Fees) to the Services Agreement is superseded and replaced in its entirety by the new Exhibit B attached hereto, which shall be effective for the contract renewal term of January 1, 2021 through December 31, 2021.

3. **Exhibit D.** Exhibit D (Business Associate Agreement) is superseded and replaced in its entirety by the new Exhibit D attached hereto, effective January 1, 2021.

4. **New Exhibit E-2.** A new Exhibit E-2 (Third Party Disclosure Agreement) for Mercer Health & Benefits LLC, as attached hereto, is added to the Services Agreement, effective January 1, 2015.

5. **New Exhibit E-3.** A new Exhibit E-3 (Third Party Disclosure Agreement) for ReliaStar Life Insurance Company (Voya), as attached hereto, is added to the Services Agreement, effective January 1, 2021.

Capitalized Terms: All capitalized terms in this Amendment shall have the same meaning given to such terms in the Services Agreement unless otherwise specified in this Amendment.

Continuation of Services Agreement: Except as specifically amended pursuant to the foregoing, the Services Agreement shall continue in full force and effect in accordance with the terms in existence as of the date of this Amendment. After the date of this Amendment, any reference to the Services Agreement shall mean the Services Agreement as amended by this Amendment.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date first written above.

By: **Providence Health Plan**

Signature: Brad Garrigues

Name: Bradley J. Garrigues

Title: Chief Sales & Marketing Officer

Date: 10/14/21

By: **Clackamas County**

Signature: _____

Name: _____

Title: _____

Date: _____

EXHIBIT B: SERVICE FEES

This Exhibit B lists the service fees you must pay us for our services under the Services Agreement for the period of: January 1, 2021 through December 31, 2021.

Core Package of Services	
	Note: PEPM means Per Employee Per Month
Medical Claims Administration	$32.45 PEPM
Pharmacy Claims Administration & Management	$5.41 PEPM (100% of rebates to Client)
Providence ASO Signature Network	$8.11 PEPM
Medical, Case and Disease Management	$9.37 PEPM
MHCD with Administration, Utilization Management and Network	$0.00 PEPM (included in Medical Claims Administration fee)
Alternative Care/Chiropractic Care Administration & Network (ASH Network; PHP processing)	$2.30 PEPM
Health Coaching – 12 Sessions	$2.12 PEPM
Stop Loss Interface Fee (Voya)	$1.00 PEPM
Total Monthly Administrative Fee	**$60.76 PEPM**
Additional Services	
Benefits Administration:	
Fiduciary Fee	Included
Terminal Claims Processing	3 X Fees (one-time fee)
Custom Reporting	$175/hr (minimum charge of $350)
Miscellaneous Consulting	$175/hr (minimum charge of $350)
SPD Printing and Distribution	At Our cost
Ancillary Services:	
HIPAA Administration (HIPAA Cert upon request)	No additional charge
Providence Nurse Advice Line	No additional charge
LifeBalance	No additional charge
TruHearing (available only in OR and SWWA)	No additional charge
ChooseHealthy (available only in OR and SWWA)	No additional charge

EXHIBIT D: BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is entered into by and between the Clackamas County Employee Flexible Benefit Plan ("Covered Entity" or "the Plan") as sponsored by Clackamas County ("Plan Sponsor") and its current and future subsidiaries and affiliates, and Providence Health Plan ("Providence") and its current and future lines of business, affiliates, and subsidiaries, on this 1st day of January, 2021 ("Effective Date"). Covered Entity, Plan Sponsor, and Providence are collectively referred to as the "Parties." This Agreement replaces and supersedes any and all prior business associate agreements between the Parties.

RECITALS

WHEREAS, the Plan is a covered entity and Providence is a business associate as such terms are defined under the Health Insurance Portability and Accountability Act and the Health Information Technology for Economic and Clinical Health Act ("HIPAA/HITECH") regarding the confidentiality and privacy of Protected Health Information (PHI); and

WHEREAS, Plan Sponsor has entered or may enter into agreement(s) with Providence ("Service Agreement") pursuant to which Providence will render services to, for or on behalf of Covered Entity which may involve Providence's use, disclosure or creation of PHI, or receipt, storage, processing or accessing of SUD records on behalf of Covered Entity in order to perform such services; and

WHEREAS, the provisions of this Agreement are specifically intended to meet the business associate contract requirements of the HIPAA/HITECH privacy standards set forth in Section 45 CFR, Section 164.504 ("Privacy Rule"), the HIPAA/HITECH Security Standards for Business Associate Contracts set forth in Section 45 CFR 164.314 ("Security Rule"), the requirements and guidance issued by United States Department of Health and Human Services ("HHS") pursuant to the American Recovery and Reinvestment Act of 2009 (42 USC Section 17931(a) et. seq.) ("ARRA"), and the requirements of 42 CFR Part 2 which prohibit the unauthorized disclosure of SUD records; and.

WHEREAS, both Covered Entity and Providence may qualify as a lawful holder of "records" from a substance use disorder ("SUD") "program," as defined in 42 CFR 2.11 and further described in 42 CFR 2.12 (b), and, as such, may be subject to the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 CFR Part 2, including disclosure requirements in 42 CFR 2.33, with respect to such SUD records disclosed by a SUD program to Covered Entity or to Providence to carry out payment and/or health care operations services on behalf of the Covered Entity.

NOW THEREFORE, in consideration of the mutual covenants, promises and agreements contained herein, the Parties hereto agree as follows:

I. DEFINITIONS

For the purposes of this Agreement, certain terms and concepts used herein shall have the definition given in HIPAA/HITECH or ARRA, or the respective implementing regulation, as applicable unless otherwise defined herein. Unless the context provides otherwise, references to "PHI" shall also include SUD records.

II. OBLIGATIONS OF PROVIDENCE

1. Use and Disclosure of Health Information

a) Providence shall comply with all applicable federal and state laws and regulations relating to maintaining and safeguarding the confidentiality of PHI and implement administrative, physical and technical safeguards, consistent with the size and complexity of Providence's operations that reasonably and

appropriately protect the confidentiality, integrity and availability of the PHI that it creates, receives, maintains or transmits on behalf of Covered Entity. Providence shall comply with such safeguards as of the applicable dates pursuant to HIPAA/HITECH and ARRA and their respective implementing regulations. Such safeguards shall include, without limitation, implementing written policies and procedures in compliance with HIPAA/HITECH and ARRA, conducting a security risk assessment, and training Providence workforce members who will have access to PHI with respect to the policies and procedures required by HIPAA/HITECH and ARRA.

b) Providence warrants that Providence, its directors, officers, subcontractors, workforce members, affiliates, agents, and representatives: (1) shall use or disclose PHI only in connection with fulfilling its duties and obligations under this Agreement and the Service Agreement; (2) shall not use or disclose PHI other than as permitted or required by this Agreement, the Service Agreement, or required by law; and (3) shall not use or disclose PHI in any manner that violates applicable federal and state laws or would violate such laws if used or disclosed in such manner by Covered Entity; and (4) shall otherwise comply with the terms of this Agreement.

c) Subject to the restrictions set forth in the previous paragraph and throughout this Agreement, Providence may use the PHI received from Covered Entity if necessary for (1) the proper management and administration of Providence; or (2) to carry out the legal responsibilities of Providence pursuant to the Service Agreement.

d) Providence acknowledges that all PHI created, received, maintained, accessed or transmitted between Providence and Covered Entity shall be and remain the sole property of Covered Entity, including any and all forms thereof developed by Providence in the course of its fulfillment of its obligations pursuant to the Agreement and Service Agreement.

e) Providence further represents that, to the extent Providence requests that Covered Entity disclose PHI to Providence, such request is only for the minimum necessary PHI for the accomplishment of the Providence's authorized purpose under the Service Agreement.

f) Providence shall also comply with any additional security requirements contained in ARRA or subsequent rules promulgated by HHS that are applicable to Business Associates.

g) Subject to the requirements of HIPAA, and excluding SUD records, the Parties acknowledge and agree that Providence shall have the right to de-identify PHI and other identifiable health data ("De-Identified Data") relating to Covered Entity and that Providence shall be the sole and exclusive owner of any aggregated De-Identified Data and any compilations or derivatives thereof. Providence may use De-Identified Data to provide, or arrange for the provision of, additional services to Plan Sponsor and other customers, or for other population health initiatives with its own delivery system affiliates. Plan Sponsor shall retain ownership of its own Plan data.

2. Access to Books and Records

a) Providence shall permit the Secretary and others required by law to audit Providence's internal practices, books and records at reasonable times as they pertain to the use and disclosure of PHI received from, or created or received by Providence on behalf of, Covered Entity in order to ensure that Covered Entity and Providence are in compliance with the requirements of the Privacy Rule and Security Rule. Notwithstanding this provision, no attorney-client, accountant-client or other legal privilege will be deemed waived by Providence or Covered Entity as a result of this subsection.

b) Providence shall provide Covered Entity with a written attestation, from an authorized representative, of compliance with HIPAA/HITECH privacy and security rules, and the terms of this Agreement, upon reasonable request of Covered Entity, and in a form mutually acceptable to Providence and Covered Entity.

3. Access of Individuals to Information

a) Providence shall within fifteen (15) days of a request by Covered Entity for access to PHI about an individual, make available to Covered Entity such PHI for so long as such information is maintained. In the event any individual requests access to PHI directly from Providence, Providence shall within five (5) business days forward such requests to Covered Entity. Any denial of access to the PHI requested shall be the responsibility of Covered Entity.

b) Providence and Covered Entity agree to work cooperatively to meet applicable requirements under 45 CFR Section 164.524.

4. Amendment of Information

Within five business days of receiving a request from Covered Entity to amend PHI about an individual contained in a Designated Record Set, Providence will provide such information to Covered Entity for amendment. If a request from Covered Entity includes specific information to be modified in a member's Designated Record Set as an amendment and, if Providence is the originator of said records, Providence will incorporate such amendment within fifteen (15) business days of receipt of the request. Providence will forward to Covered Entity within five (5) business days any requests by individuals to Providence to amend PHI within a Designated Record Set. Covered Entity will be responsible for making all determinations regarding amendments to PHI and Providence will make no such determinations.

5. Accounting for Disclosures of PHI

a) Upon Covered Entity's request, Providence shall provide to Covered Entity an accounting of each Disclosure of PHI made by Providence or its workforce members, agents, representatives, or subcontractors.

b) Providence shall implement a process that allows for an accounting to be collected and maintained for any Disclosure of PHI that HIPAA/HITECH requires Providence to maintain. Providence shall include in the accounting: (a) the date of the disclosure; (b) the name, and address if known, of the entity or person who received the PHI; (c) a brief description of the PHI disclosed; and (d) a brief statement of the purpose of the disclosure. For each disclosure that requires an accounting under this section, Providence shall document the information specified in (a) through (d), above, and shall securely retain this documentation for six years from the date of the disclosure.

c) If an individual requests an accounting of Disclosures directly from Providence, Providence will forward the request to Covered Entity within five (5) business days of Providence's receipt of the request, and will make its records of disclosures available to Covered Entity as otherwise provided in this Section. Covered Entity will be responsible to prepare and deliver the records of disclosure to the individual. Providence will not provide an accounting of its disclosure directly to the individual.

d) The provisions of this Section shall survive the termination of this Agreement.

6. Disclosures to Third Parties

a) Providence shall require each director, officer, subcontractor, workforce member, affiliate, agent, and representative that has or will have access to PHI, which is received from, or created or received by, Providence on behalf of Covered Entity, to be bound by substantially similar restrictions, terms, and conditions that apply to Providence pursuant to the Agreement with respect to such PHI. Providence shall incorporate this requirement in writing into any agreement between Providence and any of its subcontractors.

b) Providence shall also (i) obtain reasonable assurances from the person to whom the PHI is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed and (ii) obligate such person to notify Providence of any instances of which it is aware in which the confidentiality of the PHI has been Breached.

c) If Providence receives SUD records in order to provide services to Covered Entity, Providence shall implement safeguards to prevent unauthorized use and disclosure, other than as permitted by law, in accordance with 42 CFR Part 2.

7. Breaches

a) Unless state law requires otherwise, in the event of a Breach, a security incident, or any unauthorized or improper use or disclosure of any unsecured PHI or SUD record that Providence accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds or uses on behalf of Covered Entity, Providence shall report such Breach to Covered Entity without unreasonable delay, but in no event more than 15 business days after discovering the Breach. The parties acknowledge and agree that this Section 7(a) constitutes notice by Providence to Covered Entity of the ongoing existence and occurrence or attempts of unsuccessful security incidents for which no additional notice to Covered Entity shall be required. "Unsuccessful security incidents" means, without limitation, pings and other broadcast attacks on Providence's firewall, port scans, unsuccessful log-on attempts, denial of service attacks, and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of PHI.

b) Notice to Covered Entity of a Breach or suspected Breach shall include, at a minimum: (i) the identification of each individual whose PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed during the Breach, (ii) the date of the Breach, if known, (iii) the scope of the Breach, and (iv) a description of the Providence's response to the Breach. Providence agrees that notice to Covered Entity shall not be delayed due to lack of all these elements.

c) In the event of a Breach, Providence shall, in consultation with Covered Entity, mitigate, to the extent practicable, any harmful effect of such Breach that is known to Providence.

8. Return/Destruction of Protected Health Information Upon Termination

Upon termination of Agreement for any reason, Providence shall not maintain any copies of the PHI and shall return or destroy all PHI that it maintains in any form. This provision applies to PHI that is in the possession of subcontractors or agents of Providence. In the event that Providence determines that returning or destroying the PHI is infeasible, Providence shall notify Covered Entity of such a determination and shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Providence maintains such PHI. This section shall survive the termination of this Agreement.

III. OBLIGATIONS OF COVERED ENTITY

1. Use and Disclosure of PHI.

Covered Entity warrants that Covered Entity, its directors, officers, subcontractors, workforce members, affiliates, agents, and representatives: (1) shall comply with the HIPAA/HITECH in its use or disclosure of PHI; (2) shall not use or disclose PHI in any manner that violates applicable federal and state laws; (3) shall not request Providence to use or disclose PHI in any manner that violates applicable federal and state laws if such use or disclosure were done by Covered Entity; and (4) may request Providence to disclose PHI directly to another Party only for the purposes allowed by the HIPAA/HITECH. The provisions of this subsection shall survive the termination of this Agreement.

2. Covered Entity's Notice of Privacy Practices

Plan Sponsor shall be responsible for the preparation, distribution, and all expenses associated with Covered Entity's Notice of Privacy Practices ("NOPP"). To facilitate this preparation, upon Covered Entity's request, Business Associate will provide Covered Entity with Business Associate's NOPP, which Covered Entity may use in coordination with and/or the development of its own NOPP. Covered Entity will be solely responsible for the review and approval of the content of its NOPP, including whether its content accurately reflects Covered Entity's privacy policies and practices, as well as its compliance with the requirements of 45 C.F.R. § 164.520. Unless advance written approval is obtained from Business Associate, Covered Entity shall not create any NOPP that imposes obligations on Business Associate that are in addition to or that are inconsistent with the NOPP prepared by Business Associate or with the obligations assumed by Business Associate hereunder.

3. Notification of Privacy Practices and Restrictions.

Covered Entity shall notify Providence of any change to or limitations in its NOPP, either generally or with regard to an individual, in accordance with 45 CFR section 164.520, to the extent that such limitation may affect Providence's use or disclosure of PHI.

IV. TERM AND TERMINATION

1. General Term and Termination

This Agreement shall become effective on the Effective Date set forth above and shall terminate upon the termination or expiration of the Service Agreement and when all PHI provided by either Party to the other, or created or received by Providence on behalf of Covered Entity is, in accordance with subsection II.8, destroyed or returned to Covered Entity or, if it is not feasible to return or destroy PHI, protections are extended to such information, in accordance with the terms of this Agreement.

2. Material Breach

a. Where Covered Entity has knowledge of a material breach of this Agreement by Providence, Covered Entity shall have the right to terminate the Service Agreement and this Agreement immediately, provided that such termination is in accordance with and subject to any rights to cure and payment obligations specified in the Service Agreement.

b. At the discretion of Covered Entity, Providence will have the opportunity to cure any breach of Providence's obligations under this Agreement. Such breach shall be cured within 30 days.

c. In the event that either Party has knowledge of a material breach of this Agreement by the other Party and cure is not possible, the non-breaching Party shall terminate the portion of the Service

Agreement that is affected by the breach. When neither cure nor termination is feasible, the non-breaching Party shall report the problem to the Secretary.

3. Equitable Remedies

The parties agree that damages are inadequate to compensate for the unique losses to be suffered in the event of a breach of this Agreement, and that the damaged party will be entitled, in addition to any other remedy it may have under this Agreement or at law, to seek and obtain injunctive and other equitable relief, including specific performance of the terms of this Agreement without the necessity of posting bond or other security and without having to prove the inadequacy of available remedies at law, it being acknowledged and agreed that any such violation shall cause irreparable injury to the Disclosing Party and that monetary damages shall not provide an adequate remedy.

V. AMENDMENT

If any of the regulations promulgated under HIPAA/HITECH or ARRA are amended or interpreted in a manner that renders this Agreement inconsistent therewith, Covered Entity may, on 30 business days' written notice to Providence, amend this Agreement to the extent necessary to comply with such amendments or interpretations. Providence agrees that it will fully comply with all such regulations promulgated under HIPAA/HITECH or ARRA, and that it will agree to amend this Agreement to incorporate any provisions required by such regulations. This Agreement modifies and supplements the terms and conditions of the Service Agreement, and the provisions set forth herein shall be deemed a part of the Service Agreement.

VI. INDEMNIFICATION

Each of the Parties agrees to be liable for its own conduct in connection with this Business Associate Agreement and to indemnify the other Party against any and all losses therefore. In the event that loss or damage results from the conduct of more than one Party, each Party agrees to be responsible for its own proportionate share of the claimant's total damages under the laws of the State of Oregon. Each of the Parties agrees to indemnify, defend and hold harmless the other Party and its directors, officers, subcontractors, workforce members, affiliates, agents, and representatives from and against any and all third party liabilities, costs, claims, suits, actions, proceedings, demands, losses and liabilities of any kind (including court costs and reasonable attorneys' fees) brought by a third party, arising from or relating to the acts or omissions of that Party or any of its directors, officers, subcontractors, workforce members, affiliates, agents, and representatives in connection with that Party's performance under this Agreement or Service Agreement, without regard to any limitation or exclusion of damages provision otherwise set forth in the Agreement. This Section shall survive the termination of this Agreement.

VII. COUNTERPARTS

This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. In the event that any signature is delivered by facsimile transmission or by e-mail delivery of a ".pdf" format data file, such signature shall create a valid and binding obligation of the party executing (or on whose behalf such signature is executed) with the same force and effect as if such facsimile or ".pdf" signature page were an original thereof.

VIII. CONFLICTING TERMS

In the event any terms of this Agreement conflict with any terms of the Service Agreement, the terms of this Agreement shall govern and control.

IX. GOVERNING LAW

This Agreement shall be governed by and construed in accordance with the laws of the State of Oregon.

IN WITNESS WHEREOF, each of the undersigned has duly executed this Agreement on behalf of the Party and as of the Effective Date.

Plan Sponsor:	*Business Associate*:
Clackamas County	**Providence Health Plan**
By _____	By Brad Garrigues
Name _____	Name Bradley J. Garrigues
Title _____	Title Chief Sales & Marketing Officer
Date _____	Date 10/14/21

On behalf of itself and Covered Entity below:

- *Clackamas County Employee Flexible Benefit Plan*

EXHIBIT E-2: THIRD PARTY DISCLOSURE AGREEMENT

This THIRD PARTY DISCLOSURE AGREEMENT ("Agreement") is entered into by and between Clackamas County ("Plan Sponsor"), **Mercer Health & Benefits LLC** ("Third Party"), and Providence Health Plan for itself and its affiliated companies ("Providence Health Plan"), effective retroactively to January 1, 2015. These parties acknowledge and agree as follows:

Plan Sponsor and Providence Health Plan entered into an agreement ("Services Agreement") under which Providence Health Plan provides claims administration and other services for Plan Sponsor's employee welfare benefit plan ("Plan"). Plan Sponsor has retained Third Party to perform certain consulting services or an examination related to the Plan ("Services" or "Examination"), which requires access to and/or evaluation of the files, books, and records of Providence Health Plan pertaining to the Plan.

Plan Sponsor has requested that solely for purposes of the Services or Examination, Providence Health Plan disclose to Third Party certain documents, statistical information and other information which is commercially valuable, confidential, proprietary, or trade secret ("Proprietary Information') and also materials which may contain medical or other individually identifiable information ("Confidential Medical Information"). Proprietary Information and Confidential Medical Information shall collectively be referred to in this Agreement as 'Confidential Information." Providence Health Plan has agreed to disclose this Confidential Information subject to the terms of this Agreement.

Such disclosure of Confidential Information shall occur at a time and place and in a manner mutually agreed upon by the parties. Confidential Information disclosed by Providence Health Plan, its agents, subsidiaries and affiliates, to Third Party in connection with the Services or Examination, including all copies thereof, shall be used by Third Party only as permitted by this Agreement. Confidential Information shall not include information: (i) generally available to the public or generally known in the insurance industry or employee benefit consulting community prior to or during the time of the Services or Examination through authorized disclosure; (ii) obtained from a third party who is under no obligation to Providence Health Plan not to disclose such information; or (iii) required to be disclosed by subpoena, or other legal process.

Use: Third Party: (a) shall not use (deemed to include, but not be limited to, using, exploiting, duplicating, recreating, modifying, decompiling, disassembling, reverse engineering, translating, creating derivative works or disclosing Confidential Information to another person or permitting any other person to do so) or disclose Confidential Information except for purposes of the Services or Examination and as permitted by law; (b) shall limit use of Confidential Information only to its authorized employees (deemed to include employees as well as individuals who are agents or independent contractors of Third Party) who have a need to know for purposes of the Services or Examination and only the minimum necessary information to perform the Services or Examination; and (c) may release Confidential Information as permitted by law in response to a subpoena or other legal process to disclose Confidential Information, after giving Providence Health Plan reasonable prior notice of such disclosure.

At the termination of the relationship between Plan Sponsor and Third Party or at the conclusion of the Services or Examination (as applicable), Third Party shall either relinquish to Providence Health Plan, or destroy (with such destruction to be certified to Providence Health Plan), all Confidential Information. Notwithstanding anything to the contrary in the foregoing, Third Party, subject to the terms and conditions of this Agreement, may (i) retain copies of Confidential Information that it is required to retain by law or regulation, (ii) retain copies of its work product that contain Confidential Information for archival purposes or to defend its work product and (iii) in accordance with legal, disaster recovery and records retention requirements, store such copies and derivative works in an archival format (e.g., tape backups), which may not be returned or destroyed. If during the course of performance of the Services or Examination, it is discovered that this Agreement has been breached by Third Party, then all Confidential Information shall be relinquished to Providence Health Plan upon demand.

This Agreement binds the parties and their respective successors, assigns, agents, employers, subsidiaries and affiliates.

Unauthorized use or disclosure of Confidential Information by Third Party is a material breach of this Agreement, which may result in irreparable harm to Providence Health Plan for which the payment of money damages is inadequate. It is agreed that Providence Health Plan, upon adequate proof of unauthorized use, and in addition to any other remedies at law or in equity that it may have, may immediately seek injunctive relief in any court of competent jurisdiction enjoining any continuing or further breaches and may obtain entry of judgment for injunctive relief. Plan Sponsor and Third Party agree to indemnify and hold harmless Providence Health Plan with respect to any claims and any damages to the extent directly caused by Third Party's breach of this Agreement.

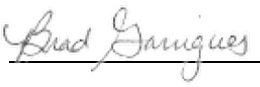
The requirement to treat all Confidential Medical Information as Confidential Information shall survive the termination of this Agreement. The requirement to treat all Proprietary Information as Confidential Information under this Agreement shall remain in full force and effect so long as any Proprietary Information remains commercially valuable, confidential, proprietary and/ or a trade secret, but in no event less than a period of three (3) years from the date of last performance of the Services or Examination.

Neither this Agreement nor Third Party's rights or obligations hereunder may be assigned without Providence Health Plan's prior written approval.

General: (a) This Agreement is the entire understanding between the parties as to the subject matter hereof. (b) No modification to this Agreement will be binding upon the parties unless evidenced in writing signed by the party against whom enforcement is sought. (c) Headings in this Agreement will not be used to interpret or construe its provisions. (d) The alleged invalidity of any term will not affect the validity of any other terms. (e) This Agreement may be executed in counterparts.

The parties have caused their authorized representatives to execute this Agreement, effective as of the date stated above.

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

By 

Name Bradley J. Garrigues

Title Chief Sales & Marketing Officer

Date 10/14/21

Clackamas County
Risk & Benefit Division
2051 Kaen Road, Suite 310
Oregon City, OR 97045

By _____

Name _____

Title _____

Date _____

Mercer Health & Benefits LLC
111 SW Columbia, Suite 500
Portland, OR 97201

By 

Name Keith Storie

Title Principal

Date 10/19/2021

EXHIBIT E-3: THIRD PARTY DISCLOSURE AGREEMENT

This THIRD PARTY DISCLOSURE AGREEMENT ("Agreement") is entered into by and between Clackamas County ("Plan Sponsor"), **ReliaStar Life Insurance Company** ("Third Party"), and Providence Health Plan for itself and its affiliated companies ("Providence Health Plan"), effective January 1, 2021. These parties acknowledge and agree as follows:

Plan Sponsor and Providence Health Plan entered into an agreement ("Services Agreement") under which Providence Health Plan provides claims administration and other services for Plan Sponsor's employee welfare benefit plan ("Plan"). Plan Sponsor has retained Third Party to perform stop loss coverage services for the Plan ("Services"), which require access to and/or an evaluation of the files, books, or records of Providence Health Plan pertaining to the Plan.

Plan Sponsor has requested that, solely for purposes of the Services, Providence Health Plan disclose to Third Party certain documents, statistical information and other information which is commercially valuable, confidential, proprietary, or a trade secret ("Proprietary Information") and also materials which may contain medical or other individually identifiable information ("Confidential Medical Information"). Proprietary Information and Confidential Medical Information will collectively be referred to in this Agreement as "Confidential Information." Providence Health Plan has agreed to disclose this Confidential Information subject to the terms of this Agreement.

Such disclosure of Confidential Information shall occur at a time and in a manner mutually agreed upon by the parties. Confidential Information disclosed by Providence Health Plan, its agents, subsidiaries and affiliates, to Third Party in connection with the Services, including all copies thereof, shall be used by Third Party only as permitted by this Agreement. Confidential Information will not include information: (i) generally available to the public or generally known in the insurance industry or employee benefit consulting community prior to or during the time of the Services through authorized disclosure; (ii) obtained from a third party who is under no obligation to Providence Health Plan not to disclose such information; or (iii) required to be disclosed by subpoena, or other legal process.

Use: Third Party: (a) shall not use (deemed to include, but not be limited to, using, exploiting, duplicating, recreating, modifying, decompiling, disassembling, reverse engineering, translating, creating derivative works or disclosing Confidential Information to another person or permitting any other person to do so) or disclose Confidential Information except for purposes of the Services and as permitted by law including, without limitation, HIPAA; (b) shall limit use of Confidential Information only to its authorized employees (deemed to include employees as well as individuals who are agents or independent contractors of Third Party) who have a need to know for purposes of the Services and only the minimum necessary to perform the Services; and (c) may release Confidential Information as permitted by law in response to a subpoena or other legal process to disclose Confidential Information, after giving Providence Health Plan reasonable prior notice of such disclosure. Notwithstanding anything to the contrary, Third Party is authorized to disclose Confidential Information in support of Third Party's legal and regulatory compliance activities in the ordinary course, including in response to requests by auditors, examiners, and regulators, without notifying Providence Health Plan or affording Providence Health Plan an opportunity to object to such disclosure.

At the termination of the relationship between Plan Sponsor and Third Party or at the conclusion of the Services (as applicable), Third Party shall either relinquish to Providence Health Plan or destroy (with such destruction to be certified to Providence Health Plan) all Confidential Information. If during the course of performance of said Services, it is discovered that this Agreement has been breached by Third Party, all Confidential Information shall be relinquished to Providence Health Plan immediately upon demand. Notwithstanding any provision of this Agreement to the contrary and only to the extent permitted by applicable law, Third Party may retain one archival copy of the Confidential Information solely for use in any dispute arising from this Agreement and for compliance purposes, provided, for the avoidance of doubt, that

any such archival copy shall remain subject to the terms and conditions set forth herein, and Third Party shall not be required to erase any computer records and/or electronic files containing Confidential Information that have been created pursuant to automatic archiving and back-up procedures in accordance with its ordinary electronic archiving or document retention policies or applicable law.

This Agreement binds the parties and their respective successors, assigns, agents, employers, subsidiaries and affiliates.

Unauthorized use or disclosure of Confidential Information by Third Party is a material breach of this Agreement resulting in irreparable harm to Providence Health Plan for which the payment of money damages is inadequate. It is agreed that Providence Health Plan, upon adequate proof of unauthorized use, and in addition to any other remedies at law or in equity that it may have, may immediately seek to obtain injunctive relief in any court of competent jurisdiction enjoining any continuing or further breaches and may obtain entry of judgment for injunctive relief. Third Party consents to Providence Health Plan seeking to obtain such injunctive relief and judgment. Plan Sponsor and Third Party agree to indemnify and hold harmless Providence Health Plan with respect to any claims and any damages caused by Third Party's breach of this Agreement.

The requirement to treat all Confidential Medical Information as Confidential Information shall survive the termination of this Agreement. The requirement to treat all Proprietary Information as Confidential Information under this Agreement shall remain in full force and effect so long as any Proprietary Information remains commercially valuable, confidential, proprietary and/or a trade secret, but in no event less than a period of three (3) years from the last date of any performance of the Services, as applicable.

Neither this Agreement nor Third Party's rights or obligations hereunder may be assigned without Providence Health Plan's prior written approval.

General: (a) This Agreement is the entire understanding between the parties as to the subject matter hereof. (b) No modification to this Agreement will be binding upon the parties unless evidenced in writing signed by the party against whom enforcement is sought. (c) Headings in this Agreement will not be used to interpret or construe its provisions. (d) The alleged invalidity of any term will not affect the validity of any other terms. (e) This Agreement may be executed in counterparts.

The parties have caused their authorized representatives to execute this Agreement, effective as of the date stated above.

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

By Brad Garrigues

Name Bradley J. Garrigues

Title Chief Sales & Marketing Officer

Date 10/14/21

Clackamas County
Risk & Benefit Division
2051 Kaen Road, Suite 310
Oregon City, OR 97045

By _____

Name _____

Title _____

Date _____

ReliaStar Life Insurance Company
20 Washington Avenue South
Minneapolis, MN 55401

By Mona Zielke

Name Mona Zielke

Title Vice President

Date 10/15/2021

2021 Summary Plan Description

Early Retirees – COBRA – Temporary Employees

Open Option

TABLE OF CONTENTS

1. INTRODUCTION 1

1.1 KEY FEATURES OF YOUR CLACKAMAS COUNTY EARLY RETIREE-COBRA-TEMPORARY EMPLOYEES OPEN OPTION PLAN 2

2. WELCOME TO PROVIDENCE HEALTH PLAN 4

2.1 CLACKAMAS COUNTY EARLY RETIREE-COBRA-TEMPORARY EMPLOYEES OPEN OPTION PLAN 4
2.2 SUMMARY PLAN DESCRIPTION 5
2.3 CUSTOMER SERVICE 5
2.4 REGISTERING FOR A MYPROVIDENCE ACCOUNT 6
2.5 YOUR MEMBER ID CARD 6
2.6 PROVIDENCE NURSE ADVICE LINE 6
2.7 WELLNESS BENEFITS 7
2.8 PRIVACY OF MEMBER INFORMATION 8

3. HOW TO USE YOUR PLAN 10

3.1 IN-NETWORK PROVIDERS 10
3.1.1 Nationwide Network of In-Network Providers 10
3.1.2 Choosing an In-Network Provider 10
3.1.3 Indian Health Services Providers 11
3.2 THE ROLE OF A PRIMARY CARE PROVIDER 11
3.2.1 Primary Care Providers 11
3.2.2 Established Patients with Primary Care Providers 11
3.2.3 Selecting a New Primary Care Provider 12
3.2.4 Changing Your Primary Care Provider 12
3.2.5 Office Visits 12
3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS 13
3.4 NOTICE OF PROVIDER TERMINATION 15
3.5 PRIOR AUTHORIZATION 15
3.6 TRAVEL EXPENSE REIMBURSEMENT 17
3.7 MEDICAL COST MANAGEMENT 17
3.7.1 Coverage of New Technology and New Application of Existing Technology 18
3.8 MEDICALLY NECESSARY SERVICES 19
3.9 APPROVED CLINICAL TRIALS 19
3.10 HOW BENEFITS ARE APPLIED 19
3.11 DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS 20
3.11.1 Understanding Deductibles 20
3.11.2 Understanding Out-of-Pocket Maximums 20

4. COVERED SERVICES 22

4.1 PREVENTIVE SERVICES 22
4.1.1 Physical Examinations and Well-Baby Care 22
4.1.2 Immunizations and Vaccinations 23
4.1.3 Prostate Cancer Screening Exams 23
4.1.4 Colorectal Cancer Screening Exams 23

4.1.5 Preventive Services for Members with Diabetes 24
4.1.6 Diabetes Self-Management Education Program 24
4.1.7 Nutritional Counseling 24
4.1.8 Tobacco Use Cessation Services 24
4.2 WOMEN'S PREVENTIVE HEALTH CARE SERVICES 25
4.2.1 Gynecological Examinations 25
4.2.2 Mammograms 25
4.2.3 Breastfeeding Counseling and Support 25
4.2.4 Family Planning Services 25
4.3 PROVIDER SERVICES 26
4.3.1 Office Visits, Inpatient and Outpatient Hospital Visits, and Home Visits 26
4.3.2 Virtual Visits 26
4.3.3 E-mail Visits 27
4.3.4 Telemedical Services 27
4.3.5 Allergy Shots, Allergy Serums, Injectable and Infused Medications 28
4.3.6 Administration of Anesthesia and Surgical Procedures 28
4.3.7 Immediate Care 28
4.3.8 Retail Health Clinic 29
4.4 DIAGNOSTIC SERVICES 29
4.4.1 Diagnostic Pathology, Radiology Tests, High Tech Imaging and Diagnostic Procedures 29
4.4.2 Sleep Study Services 29
4.5 EMERGENCY CARE AND URGENT CARE SERVICES 29
4.5.1 Emergency Care 29
4.5.2 Emergency Medical Transportation 31
4.5.3 Emergency Eye Care Services 31
4.5.4 Emergency Detoxification Services 31
4.5.5 Urgent Care 32
4.6 INPATIENT HOSPITAL AND SKILLED NURSING FACILITY SERVICES 32
4.6.1 Inpatient Hospital Services 33
4.6.2 Skilled Nursing Facility 33
4.6.3 Inpatient Rehabilitative Care 34
4.6.4 Inpatient Habilitative Care 34
4.6.5 Observation Care 34
4.7 OUTPATIENT SERVICES 34
4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy 34
4.7.2 Outpatient Rehabilitative Services 35
4.7.3 Outpatient Habilitative Services 35
4.8 MATERNITY SERVICES 35
4.9 MEDICAL SUPPLIES, MEDICAL APPLIANCES, PROSTHETIC AND ORTHOTIC DEVICES AND DURABLE MEDICAL EQUIPMENT (DME) 37
4.9.1 Medical Supplies (including Diabetes Supplies) 37
4.9.2 Medical Appliances 38
4.9.3 Prosthetic and Orthotic Devices 38

4.9.4 Durable Medical Equipment (DME) 38
4.10 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES 39
4.10.1 Mental Health Services 39
4.10.2 Applied Behavior Analysis 39
4.10.3 Substance Abuse Services 40
4.11 HOME HEALTH CARE AND HOSPICE CARE 40
4.11.1 Home Health Care 40
4.11.2 Hospice Care 41
4.12 OTHER COVERED SERVICES 41
4.12.1 Genetic Testing and Counseling Services 41
4.12.2 Inborn Errors of Metabolism 42
4.12.3 Podiatry/Foot Services 42
4.12.4 Reconstructive Surgery 42
4.12.5 Reconstructive Breast Surgery 42
4.12.6 Restoration of Head/Facial Structures; Limited Dental Services 43
4.12.7 Temporomandibular Joint (TMJ) Services 44
4.12.8 Self-Administered Chemotherapy 44
4.12.9 Chiropractic Manipulation 44
4.12.10 Acupuncture 44
4.12.11 Gender Dysphoria 44
4.12.12 Elective Sterilization 45
4.12.13 Hearing Loss Services 45
4.12.14 Wigs 46
4.12.15 Biofeedback 46
4.13 HUMAN ORGAN/TISSUE TRANSPLANTS 46
4.13.1 Covered Services 46
4.13.2 Benefits for Transplant Facility Services Provided to the Organ Recipient 47
4.13.3 Benefits for Outpatient Medications 48
4.13.4 Benefits for Physician/Provider Services Provided to the Organ Recipient 48
4.13.5 Transplant Prior Authorization 48
4.13.6 Transplant Exclusions 48
4.14 PRESCRIPTION DRUG BENEFIT 49
4.14.1 Using Your Prescription Drug Benefit 49
4.14.2 Use of Out-of-Network Pharmacies 50
4.14.3 Prescription Drug Formulary 51
4.14.4 Prescription Drugs 51
4.14.5 Prescription Drug Quantity 52
4.14.6 Participating Mail-Order and Preferred Retail Pharmacies 52
4.14.7 Prescription Drug Limitations 52
4.14.8 Prescription Drug Exclusions 54
4.14.9 Prescription Drug Disclaimer 54
5. EXCLUSIONS 55
6. CLAIMS ADMINISTRATION 61
6.1 CLAIMS PAYMENT 61
6.1.1 Timely Submission of Claims 62

6.1.2 Right of Recovery 62
6.2 COORDINATION OF BENEFITS 63
6.2.1 Definitions Relating to Coordination of Benefits 63
6.2.2 Order of Benefit Determination Rules 65
6.2.3 Effect on the Benefits of This Plan 67
6.2.4 Right to Receive and Release Needed Information 67
6.2.5 Facility of Payment 67
6.2.6 Right of Recovery 67
6.2.7 Coordination with Medicare 68
6.3 THIRD-PARTY LIABILITY/SUBROGATION 68
6.3.1 Third-Party Liability/Subrogation and How It Affects You 68
6.3.2 Proceeds of Settlement or Recovery 69
6.3.3 Suspension of Benefits and Reimbursement 70
6.3.4 Special Rules for Motor Vehicle Accident Cases 71

7. PROBLEM RESOLUTION 72
7.1 INFORMAL PROBLEM RESOLUTION 72
7.2 MEMBER GRIEVANCE AND APPEAL 72
7.2.1 Your Grievance and Appeal Rights 73
7.2.2 Internal Grievance or Appeal 74
7.2.3 External Review 74
7.2.4 How to Submit Grievances or Appeals and Request Appeal Documents 75

8. ELIGIBILITY AND ENROLLMENT 76
8.1 EMPLOYEE ELIGIBILITY AND ENROLLMENT 76
8.1.1 Employee Eligibility Date 76
8.1.2 Employee Effective Date 76
8.1.3 Employee Enrollment 76
8.2 DEPENDENT ELIGIBILITY AND ENROLLMENT 76
8.2.1 Eligibility Date 76
8.2.2 Additional Requirements for Eligible Family Dependent Coverage 76
8.2.3 Eligible Family Dependent Enrollment 77
8.2.4 Newborn Eligibility and Enrollment 77
8.2.5 Open Enrollment Period 77
8.2.6 Changes in Eligibility 77
8.2.7 Members No Longer Eligible for Coverage 77
8.3 SPECIAL ENROLLMENT PERIODS 78
8.3.1 Loss of Other Coverage 78
8.3.2 New Dependents 79
8.3.3 Court Orders 79
8.3.4 Premium Assistance 79
8.4 LEAVE OF ABSENCE AND LAYOFFS 80

9. TERMINATION OF MEMBER COVERAGE 81
9.1 TERMINATION DATES 81
9.2 TERMINATION AND RESCISSION OF COVERAGE DUE TO FRAUD OR ABUSE 81
9.3 NON-LIABILITY AFTER TERMINATION 81

9.4 DISENROLLMENT FROM THIS PLAN 82
9.5 NOTICE OF CREDITABLE COVERAGE 82
9.6 CLACKAMAS COUNTY'S RIGHT TO TERMINATE OR AMEND PLAN 82
10. CONTINUATION OF GROUP MEDICAL BENEFITS 83
10.1 COBRA CONTINUATION COVERAGE 83
10.1.1 Subscriber's Continuation Coverage 83
10.1.2 Spouse's or Domestic Partner's Continuation Coverage 83
10.1.3 Dependent's Continuation Coverage 83
10.1.4 Notice Requirements 84
10.1.5 Type of COBRA Continuation Coverage 84
10.1.6 COBRA Election Rights 84
10.1.7 COBRA Premiums 84
10.1.8 Length of COBRA Continuation Coverage 84
10.1.9 Extension of Continuation Period 85
10.1.10 Trade Act of 2002 85
10.1.11 When COBRA Continuation Coverage Ends 86
11. MEMBER RIGHTS AND RESPONSIBILITIES 87
11.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES 87
11.2 INFORMATION FOR NON-ERISA MEMBERS (PARTICIPANTS) 88
12. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO) 90
12.1 DEFINITIONS 90
12.2 NOTICE UPON RECEIPT OF ORDER 90
12.3 NOTICE OF DETERMINATION 90
12.4 ENROLLMENT OF ALTERNATE RECIPIENT 91
12.5 COST OF COVERAGE 91
12.6 REIMBURSEMENT OF PLAN EXPENSES 91
12.7 STATUS OF ALTERNATE RECIPIENT 92
12.8 TREATMENT OF NATIONAL MEDICAL SUPPORT NOTICE 92
13. GENERAL PROVISIONS 93
13.1 CONFLICTS OF PROVISIONS 93
13.2 CONTROLLING STATE LAW 93
13.3 DUPLICATING PROVISIONS 93
13.4 FAILURE TO PROVIDE INFORMATION OR PROVIDING INCORRECT OR INCOMPLETE INFORMATION 93
13.5 GENDER AND NUMBER 93
13.6 HEADINGS 93
13.7 LEGAL ACTION 94
13.8 LIMITATIONS AND PROVISIONS 94
13.9 MEMBER RESPONSIBILITY 94
13.10 MEMBERSHIP ID CARD 94
13.11 NON-TRANSFERABILITY OF BENEFITS 94
13.12 NO GUARANTEE OF EMPLOYMENT 94
13.13 NO RECOURSE FOR ACTS OF PROVIDERS 95
13.14 NON-WAIVER 95

13.15 NOTICE 95
13.16 NOTICE REQUIRED FOR REIMBURSEMENT AND PAYMENT OF CLAIM 95
13.17 PAYMENT OF BENEFITS TO PERSONS UNDER LEGAL DISABILITY 95
13.18 PHYSICAL EXAMINATION AND AUTOPSY 96
13.19 PROFESSIONAL REVIEW AND RIGHT TO EXAMINE RECORDS 96
13.20 REQUIRED INFORMATION TO BE FURNISHED 96
13.21 RIGHT OF RECOVERY 96
13.22 SEVERABILITY 96
13.23 STATE MEDICAID BENEFITS RIGHTS 96
13.24 SUGGESTIONS 97
13.25 VETERANS' RIGHTS 97
13.26 WORKERS' COMPENSATION INSURANCE 97
14. PLAN ADMINISTRATION 98
14.1 TYPE OF ADMINISTRATION 98
14.2 PLAN INFORMATION 98
14.3 PLAN DATES 98
14.4 PLAN SPONSOR INFORMATION 98
14.5 ADMINISTRATIVE SERVICES PROVIDED BY 98
14.6 AGENT FOR SERVICE OF LEGAL PROCESS 98
14.7 ADMINISTRATIVE SERVICES 99
14.7.1 Complete Allocation of Fiduciary Responsibilities 99
14.8 ENGAGEMENT OF ADVISORS 99
14.9 INDEMNIFICATION 99
14.10 AMENDMENT OR TERMINATION OF PLAN 99
14.10.1 Right to Amend or Terminate 99
14.10.2 Manner of Action 100
14.10.3 Effect on Benefits 100
14.11 PROTECTED HEALTH INFORMATION 100
14.11.1 Disclosure 100
14.11.2 Security 101
15. DEFINITIONS 102
16. NON-DISCRIMINATION STATEMENT 115

1. INTRODUCTION

Statement from Plan Sponsor

Clackamas County has designed this Plan in cooperation with Providence Health Plan. The benefits under the Plan are provided by Clackamas County on a self-insured basis. Clackamas County 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.

Clackamas County Benefits & Wellness: 503-655-8550

Customer Service Quick Reference Guide:

Medical 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 Chemical Dependency 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)
Providence Resource Line To find a care provider or to register for Providence classes	503-574-6595
myProvidence Help Desk	503-216-6463 877-569-7768
LifeBalance	503-234-1375 888-754-LIFE (toll-free) www.LifeBalanceProgram.com
Provider Directory	ProvidenceHealthPlan.com/findaprovider

1.1 KEY FEATURES OF YOUR CLACKAMAS COUNTY EARLY RETIREE-COBRA-TEMPORARY EMPLOYEES OPEN OPTION PLAN

- Some capitalized terms have special meanings. Please see section 15, Definitions.
- In this Summary Plan Description, Providence Health Plan and Clackamas County 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;
  - Providence Health Plan's 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 3 and your Plan Benefit Summary for additional information.
- Some Services are covered only under your In-Network benefits:
  - Web-direct Visits, as specified in section 4.3.2;
  - E-mail Visit Services, as specified in section 4.3.3;
  - Temporomandibular Joint (TMJ) Services, as specified in section 4.12.7;
  - Tobacco Use Cessation Services, as specified in section 4.1.8;
  - Water births, as specified in section 4.8;
  - Human Organ/Tissue Transplant Services, as specified in section 4.13; and
  - Any item listed in your Benefit Summary as "Not Covered" Out-of-Network.
- Coverage is provided in full for most preventive Services when those Services are received from specified In-Network Providers. See your Benefit Summary for additional information.
- 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 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 3.5.**
- Coverage limitations and exclusions apply to certain Services, as stated in sections 3, 4, and 5 and the Benefit Summary.
- 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 Plan documents. 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 or amendments that accompany these documents, the agreement between Providence Health Plan and the Plan Sponsor (if any), 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) Providence Health Plan/ Plan Sponsor agreement, (3) Summary Plan Description, (4) Benefit Summary(ies), and (5) 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 Clackamas County Employees and their Dependents.

2.1 CLACKAMAS COUNTY EARLY RETIREE-COBRA-TEMPORARY EMPLOYEES OPEN OPTION PLAN

Your Clackamas County Early Retiree-COBRA-Temporary Employees Open Option 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 us to Prior Authorize treatment. If you receive Covered Services from Out-of-Network Providers, it is your responsibility to make sure the Services listed in section 3.5 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 participating with Providence Health Plan, 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 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 for what you owe later. 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 Clackamas County. 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 15. 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:

- **Clackamas County Early Retiree-COBRA-Temporary Employees Open Option Medical Benefit Summary** and any other Benefit Summary documents issued with this Plan. These documents are available at www.ProvidenceHealthPlan.com when you register for a myProvidence account as explained in section 2.4. Benefit Summaries detail your Deductible, 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 or check with your Employer's human resource department 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.
- 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. 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. If you have questions or need assistance registering for or accessing an existing account, contact myProvidence customer service at 877.569.7768

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 confer 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:

- Visit your health care provider or facility.
- Register online for your myProvidence account.
- Call for Mental Health/Substance Abuse 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 recorded message, a registered nurse will come on line to assist you.

Please have your Member ID Card available when you call.

2.7 WELLNESS BENEFITS

Providence Resource Line — 503-574-6595; 800-562-8964

Providence Resource Line is your connection to information and services on classes, self-help materials, tobacco-use cessation services, and for referrals to Providence Health Plan In-Network Providers and to Providence Health & Services programs and services. Services and health-education vary by geographic service area.

Health Education

Providence Health Plan offers a wide variety of classes to help you achieve healthy lifestyle and wellness goals. We can assist you in learning to eat right and manage your weight, prepare for childbirth and much more. If you have diabetes, health education classes also are available (see section 4.1.6, for further information).

Providence Health Plan Members receive discounts on health education classes. Your costs, services and the health education classes available may vary by geographic-service area. For more information on classes available in your area, call the Providence Resource Line at 503-574-6595 or 800-562-8964 or visit www.providence.org/classes.

Health Coaching

Providence Health Plan offers Members free coaching support for weight loss, diabetes prevention, nutrition, stress management, exercise, sleep and tobacco cessation. For more information on health coaching, call 503-574-6000 (TTY: 711) or 888-819-8999 or visit www.ProvidenceHealthPlan.com/healthcoach.

Care Management

Providence Care Management provides Members with information and assistance with healthcare navigation, as well as managing chronic conditions from a Registered Nurse Care Manager.

You can access these Services by calling 800-662-1121 or e-mailing caremanagement@providence.org.

Tobacco Use Cessation

Your Wellness Benefits include access to tobacco-use cessation programs provided through our Providence Health & Services Hospitals as well as through Quit for Life. These programs address tobacco dependence through a clinically proven, comprehensive approach to tobacco-use cessation that treats all three aspects of tobacco use – physical addiction, psychological dependence and behavioral patterns. (See section 4.1.8 regarding coverage for Tobacco-Use Cessation Services).

More information about our Tobacco-Use Cessation programs can be found online at http://www.providence.org/healthplans/members/healthbalance/smokingcessation.aspx, or by calling 503-574-6595 or 800-562-8964.

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

Wellness information on our website — www.ProvidenceHealthPlan.com

Visit Providence Health Plan online at www.ProvidenceHealthPlan.com for medical information, class information, information on extra values and discounts and a wide array of other information described with your good health in mind. You also may set up your own myProvidence account to gain access to your specific personal health plan information. See *Registering for a myProvidence account*, section 2.4, for more details.

LifeBalance — 503-234-1375 or 888-754-LIFE www.LifeBalanceProgram.com

This program offers exclusive discounts to Providence Health Plan Members on a wide variety of health and wellness programs, as well as recreational, cultural and wellness activities. You can save on professional instruction, fitness club memberships, yoga classes, and much more. You also have access to discounted events, such as white-water rafting, ski trips, theater nights, and sporting events.

Learn more by visiting the LifeBalance website at www.LifeBalanceProgram.com or calling LifeBalance at 503-234-1375 or 888-754-LIFE. Please have your Providence Health Plan Member ID Card ready when you request LifeBalance discounts.

Assist America

Your wellness benefits include access to travel assistance services and identity theft protection services.

Travel Assistance Services include emergency logistical support to members traveling internationally or people traveling 100 miles from home. Learn more by visiting www.assistamerica.com or calling Assist America at 609-986-1234 or 800-872-1414.

Assist America also provides identity theft protection services 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. Please have your Providence Health Plan Member ID card ready, 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 https://healthplans.providence.org/members/rights-notices or by calling Customer Service.

Appointment of Authorized Representative

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

Confidentiality and your Employer

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

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

1. In compliance with the applicable provisions of HIPAA; and
2. Due to a HIPAA compliant authorization, the Member has completed to allow the Employer access to the Member's PHI; or
3. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer. The details of this required certification can be reviewed at https://healthplans.providence.org/about-us/privacy-notices-policies/protected-health-information-and-your-employer/.

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. HOW TO USE YOUR PLAN

Our goal is maintaining your health by promoting wellness and preventive care. We encourage you to work closely with one provider, your 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 section 4 of this Summary Plan Description.

3.1 IN-NETWORK PROVIDERS

Providence Health Plan has contractual arrangements with certain physicians/providers, hospitals and facilities. Our agreements with these "In-Network Providers" enable you to receive quality health care for a reasonable 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.

3.1.1 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 of Oregon and southwest Washington.

3.1.2 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 the Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider. If you do not have access to our website, please call Customer Service to request In-Network Provider Information.

Advantages of 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 3.5.
- 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 an In-Network Primary Care Provider, whenever possible.

3.1.3 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 St., Ste. 800
Portland, OR 97209
Telephone: 503-414-5555

3.2 THE ROLE OF A PRIMARY CARE PROVIDER

To encourage optimum health, we promote wellness and preventive care. We also believe wellness and overall health is enhanced by working closely with one physician or provider – your 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 an In-Network Primary Care Provider as soon as possible.

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

3.2.2 Established Patients with Primary Care Providers

If you and your family already see a provider, you may want to check the provider directory to see if your provider is an In-Network Primary Care Provider for Providence Health Plan. If your provider is participating with us, let their office know you are now a Providence Health Plan Member.

3.2.3 Selecting a New Primary Care Provider

We recommend 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 they are 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.

3.2.4 Changing Your Primary Care Provider

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.

3.2.5 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 the Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider, or call Customer Service to choose a specialist who 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. (For certain Plans, there is a Member Copayment for specialist visits instead of a Coinsurance. If you are on one of these Plans, you will need to pay your Member Copayment at the time of your visit. Please check your Benefit Summary for your specific coverage information.)

Alternative Care Providers

This Plan includes coverage for office visits to alternative care providers, as listed in your Benefit Summary. See section 15 for the definition of Alternative Care Provider. For coverage of chiropractic manipulation and acupuncture, see sections 4.12.9, 4.12.10 and your Benefit Summary.

3.3 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 3.5 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.

IMPORTANT NOTE: Your Plan only pays for Covered Services received from Out-of-Network Providers at Usual, Customary, and Reasonable rates (UCR) (see Section 15, 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 Summary Plan Description. Your Plan will only pay for Medically Necessary Covered Services. No matter what type of provider you see, the treatments, supplies, and medications excluded by this Plan are not covered.

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

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

- Web-direct Visits (see section 4.3.2).
- E-mail Visits (see section 4.3.3).
- Temporomandibular Joint (TMJ) Services (see section 4.12.7).
- Tobacco Use Cessation Services (see section 4.1.8).
- Retail Health Clinic visits (see section 4.3.8).
- Human Organ/Tissue Transplants (see section 4.13).
- Any item listed in your Benefit Summary as "Not Covered" under Out-of-Network.

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

After you meet your Deductible, if applicable, and if the Services provided are Medically Necessary Covered Services, we will provide payment to Out-of-Network Providers according to Usual, Customary and Reasonable (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 15 for the definition of UCR.

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

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

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

Payment for 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.

3.4 NOTICE OF PROVIDER TERMINATION

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

3.5 PRIOR AUTHORIZATION

While Prior Authorization is a requirement for coverage of certain Services under this Plan, Prior Authorization is not a treatment directive. The actual course of medical treatment that a Member chooses remains strictly a matter between the Member and the 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 Medical Necessity.

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. You or your Out-of-Network provider must contact us to obtain Prior Authorization. See section 3.3 for additional information about Out-of-Network Providers.

Services requiring Prior Authorization:

- All inpatient admissions to a Hospital (not including emergency room care), Skilled Nursing Facility or a rehabilitation facility, all emergency hospitalizations (we need to be notified within 48 hours, or as soon as reasonably possible), and all Hospital and birthing center admissions for maternity/delivery Services.
- All outpatient surgical procedures.
- Anesthesia Care with Diagnostic Endoscopy.
- All Travel Expense Reimbursement, as provided in section 3.6.
- All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services for Mental Health and Substance Abuse, as provided in sections 4.10.1 and 4.10.3.
- All Applied Behavior Analysis, as provided in section 4.10.2.
- All Human Organ/Tissue Transplant Services, as provided in section 4.13.
- All Restoration of Head/Facial Structures; Limited Dental Services, as provided in section 4.12.6.
- All Temporomandibular Joint (TMJ) Services, as provided in section 4.12.7.
- All High Tech Imaging, including PET, CT, CTA, MRI and MRA, Nuclear Cardiac Study Services, and echocardiography Services, as provided in section 4.4.1.
- All Sleep Study Services, as provided in section 4.4.2.
- Certain Home Health Care Services, as provided in section 4.11.1.
- Certain Hospice Care Services, as provided in section 4.11.2.

- Certain Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment, as provided in section 4.9.
- Certain outpatient services including, but not limited to, neurodevelopmental therapy, neurological testing, and botulinum therapies.
- All outpatient hospitalization and anesthesia for dental Services, as provided in section 4.12.6.
- All Genetic Testing Services, as provided in section 4.12.1.
- Certain medications, including certain immunizations, received in your Provider's office, as provided is sections 4.3.5 and 4.1.2.
- Certain prescription drugs specified in our Formulary, as provided in section 4.14.1.
- Certain infused Prescription Drugs administered in a hospital-based infusion center, as provided in section 4.7.1.

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 section 3.3, a 50% **penalty,** not to exceed $2,500 for each Covered Service, will be applied to the claim.

Should Providence Health Plan 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.

3.6 TRAVEL EXPENSE REIMBURSEMENT

Subject to Prior Authorization, if you are unable to locate an In-Network Provider to provide Medically Necessary Covered Services for your specific condition within 50 miles of your home, the Plan will reimburse your travel expense to the nearest In-Network Provider within 300 miles of your home. Reimbursement will be based on the federal medical mileage reimbursement rate in effect on the date of service. Travel expense reimbursement is limited to $1,500 per calendar year. If an overnight stay is required, food and lodging are reimbursable up to $150 per diem (per day). Per diem expenses apply to the $1,500 travel expenses reimbursement maximum. (Note: Transplant Covered Services include a separate travel expense benefit; see section 4.13.1).

3.7 MEDICAL COST MANAGEMENT

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

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 Services 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.

3.7.1 Coverage of New Technology and New Application of Existing Technology

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

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

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

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

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

<u>Technology Evaluation Process</u>

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

<u>Expedited Review</u>

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

3.8 MEDICALLY NECESSARY SERVICES

We believe our Members are entitled to comprehensive medical care within the standards of good medical practice. Providence Health Plan's medical directors and special committees of In-Network Providers determine which Services are Medically Necessary, as defined in section 15. 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 our guidelines. Obtaining confirmation of coverage from Providence Health Plan beforehand is always recommended.

3.9 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, the Plan 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.

3.10 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.

3.11 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.

3.11.1 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 us. Deductible amounts are payable to your Qualified Practitioner after we have processed your claim.

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

Common In-Network and Out-of-Network Deductible: Your Plan has a **Common Deductible**, as listed in your Benefit Summary. **A Common Deductible applies to both In-Network and Out-of-Network benefits**. The Common 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 the 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 amount shown in the Benefit Summary that applies when two or more 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.

3.11.2 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.

Common In-Network and Out-of-Network Out-of-Pocket Maximums: Your Plan has a Common In-Network and Out-of-Network Out-of-Pocket Maximum, as listed in your Benefit Summary. The Common Out-of-Pocket Maximum can be met by 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 two or more must pay in a Calendar Year, as shown in the Benefit Summary, before the Plan begins to pay 100%* for Covered Services for enrolled Family Members. When the combined Copayment, Coinsurance and Deductible expenses of enrolled Family Members meet the family Out-of-Pocket Maximum, all remaining individual Out-of-Pocket Maximums will be waived for the family for that Calendar Year.

Note: Once any 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 by this Plan;
- Services not covered because Prior Authorization was not obtained, as required in section 3.5;
- 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; and
- Any penalties you must pay if you do not follow 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. COVERED SERVICES

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

Please refer to your Benefit Summary for details of your specific coverage. You can view your Member materials by registering for a myProvidence account on our website at www.ProvidenceHealthPlan.com (see section 2.4). If Clackamas County modifies your benefits, you will be notified in writing of the changes.

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

4.1 PREVENTIVE SERVICES

Preventive Services are covered as shown in the Benefit Summary. For Women's Preventive Health Care Services, see section 4.2.
In accordance with the Patient Protection and Affordable Care Act of 2010 and related legislation, your Plan covers the following Services in full when received from In-Network Providers:

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

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

4.1.1 Physical Examinations and Well-Baby Care

Periodic health exams and well-baby care Services are covered in full only when received In-Network. These services are covered as stated in your Benefit Summary. Your provider will determine which tests are necessary for your physical exam according to your medical history and your current health status. More frequent exams will be covered if your provider determines that they are necessary. Vision and hearing screening services are covered when performed during a periodic health examination or well-baby care examination. In order for a child to be eligible for benefits for routine newborn baby care, the child must be properly enrolled as outlined in section 8. Ancillary Services, such as immunizations, are covered at the specified benefit level when billed by the provider.

Recommended Guidelines:

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. The Plan will not cover this additional fee.

Covered Services do **NOT** include the following:

1. Services for laser surgery, radial keratotomy and any other surgery to correct myopia, hyperopia or stigmatic error, vision therapy, orthoptic treatment (eye exercises);
2. Services for routine eye and vision care, refractive disorders, eyeglass frames and lenses, contact lenses; and
3. Hearing aids, including all Services related to the examination and fitting of hearing aids; except as specified in section 4.12.13.

4.1.2 Immunizations and Vaccinations

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

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

4.1.3 Prostate Cancer Screening Exams

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

4.1.4 Colorectal Cancer Screening Exams

Benefits for colorectal cancer screening examinations for Members age 50 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.

For Members age 50 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 50:

- 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.

4.1.5 Preventive Services for Members with Diabetes

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

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

4.1.6 Diabetes Self-Management Education Program

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

4.1.7 Nutritional Counseling

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

4.1.8 Tobacco Use Cessation Services

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

4.2 WOMEN'S PREVENTIVE HEALTH CARE SERVICES

Women may choose to receive Women's Preventive Health Care Services from a Primary Care Provider or a Women's Health Care Provider. Women's Health Care Providers include physicians specializing in obstetrics, some Primary Care Provider 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.

4.2.1 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 4.2.4). Benefits also include follow-up exams for any medical conditions discovered during an Annual gynecological exam that require additional treatment.

4.2.2 Mammograms

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

4.2.3 Breastfeeding Counseling and Support

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

4.2.4 Family Planning Services

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

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

- Intrauterine device (IUD) insertion and removal;
- Medical exams and consultation for family planning;
- Depo-Provera to prevent pregnancy;
- Diaphragm devices;
- Removal of implantable contraceptives; and
- Oral contraceptives (birth control pills) listed in our Formulary. FDA-approved women's prescription contraceptives: up to 3 months initial dispensing, then up to 12 months subsequent dispensing at any Network Pharmacy.

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 your medical supply benefit.

For coverage of tubal ligation, see Elective Sterilization, section 4.12.12.

4.3 PROVIDER SERVICES

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

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

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

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

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

4.3.2 Virtual Visits

The Plan provides coverage for Virtual Visits using secure internet technology:

- Phone and Video Visits: Phone and Video Visits are covered as shown in your Benefit Summary. All Phone and Video Visits must be Medically Necessary and may be received from authorized In-Network or Out-of-Network Providers. Not all Providers are contracted with us to provide Phone and Video Visits. Providers who are authorized to provide Phone and Video Visits have agreed to use secure internet technology approved by us to protect your information from unauthorized access or release.
- Web-direct Visits: Web-direct Visits for common conditions such as cold, flu, sore throat, allergy, ear ache, sinus pain, or UTI are covered as shown in your Benefit Summary. The Member completes a questionnaire to describe the common condition. The questionnaire is reviewed by an In-Network Provider who makes a diagnosis and sends a treatment plan back to the Member. If needed, a prescription is sent to the Member's pharmacy. All Web-direct Visits must be Medically Necessary and received from authorized In-Network Providers.

4.3.3 E-mail Visits

E-mail Visits are covered in full and must be received from In-Network Providers. Not all In-Network Providers offer E-mail Visits. Medical doctors (M.D.), doctors of osteopathy (D.O.), nurse practitioners (N.P.) and physician assistants (P.A.) are the only categories of providers 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 the Plan;
- 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 Abuse Covered Services (as provided in section 4.10).

4.3.4 Telemedical Services

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

- Is Medically Necessary;
- Is provided by a Qualified Practitioner;
- Is determined to be safely and effectively provided using synchronous two-way interactive video conferencing according to generally accepted health care practices and standards; and

- The application and technology used to provide the Telemedical Service meet all standards required by state and federal laws governing the privacy and security of protected health information.

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

4.3.5 Allergy Shots, Allergy Serums, Injectable and Infused Medications

Allergy shots, allergy serum, injectable medications, and total parenteral nutrition (TPN) received in your Provider's office are covered as shown in your Benefit Summary. Therapy and testing for treatment of allergies including, but not limited to, Services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment are covered only when such therapy or testing is approved by the American Academy of Allergy and Immunology, or the Department of Health and Human Services or any of its offices or agencies. Some injectable medications may require Prior Authorization, as listed in the Medical benefit drug prior authorization list available on our website at https://healthplans.providence.org/members/pharmacy-resources/Pages/default.aspx or by calling Customer Service. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. See section 4.7.1 for coverage of infusion at Outpatient Facilities.

4.3.6 Administration of Anesthesia and Surgical Procedures

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

4.3.7 Immediate Care

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

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

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

4.3.8 Retail Health Clinic

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

4.4 DIAGNOSTIC SERVICES

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

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

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

4.4.2 Sleep Study Services

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

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

4.5 EMERGENCY CARE AND URGENT CARE SERVICES

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

4.5.1 Emergency Care

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

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

Coverage is provided without Prior Authorization for Emergency Medical Screening Exams and stabilization of an Emergency Medical Condition. Hospitalization for an Emergency

Medical Condition requires notification to Providence Health Plan within 48 hours, or as soon as reasonably possible following the onset of treatment, in order for coverage to continue.

Definitions:
"Emergency Medical Condition" is a medical condition that manifests itself by acute symptoms of sufficient severity that a prudent layperson, possessing an average knowledge of health and medicine, would reasonably expect that failure to receive immediate medical 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:

- An Emergency Medical Screening Exam or a behavioral health assessment that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
- Such further medical examination and treatment as are required under the Emergency Medical Treatment and Active Labor Act (42 U.S.C. 1395dd) to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at the Hospital.

"*Emergency Medical Screening Exams"* include medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.

Your Plan covers Emergency Services in the emergency room of any Hospital. **Emergency room Services are covered when your medical condition meets the guidelines for emergency care as stated above. Coverage includes Services to stabilize an Emergency Medical Condition and Emergency Medical Screening Exams.**

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

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

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

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

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

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

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

Note: While Emergency Services received from Out-of-Network Providers at Out-of-Network Facilities are covered under your In-Patient benefit until the time that your condition becomes stable, the Out-of-Network Providers and Out-of-Network Facilities are not contracted with Providence Health Plan. Therefore, the claims are priced using Usual, Reasonable and Customary (UCR) pricing, as described in section 3.3. Unless otherwise prohibited by state or federal law, you may be billed by the Out-of-Network Providers and Out-of-Network Facilities for amounts above the Allowed Amount of the claim, as determined by UCR.

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

4.5.2 Emergency Medical Transportation

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

4.5.3 Emergency Eye Care Services

Covered Services include the initial care for Emergency Medical Conditions 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.

4.5.4 Emergency Detoxification Services

Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a Substance Abuse treatment program, as stated in section 4.10.3, 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. Continuing or follow-up care is not a Covered Service unless Prior Authorized by Providence Health Plan.

4.5.5 Urgent Care

Urgent Care is treatment you need right away for an illness or injury that is not life threatening. This includes, but is not limited to, minor sprains, minor cuts and burns, and ear, nose, and throat infections. Routine care that can be delayed until you can be seen by a physician or provider in their 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. They may either suggest that you come to the office or go to an emergency room or Urgent Care center. If you can be treated in your provider's office or at an In-Network Urgent Care center, your out-of-pocket expense will usually be lower.

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

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

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

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

If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will 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 6.1.1.

4.6 INPATIENT HOSPITAL AND SKILLED NURSING FACILITY SERVICES

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

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

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

- Non-skilled care for senile deterioration, mental deficiency, or developmental disability.

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

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

4.6.1 Inpatient Hospital Services

Benefits are provided as shown in 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 an In-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; and
- Hospital services and supplies necessary for treatment and furnished by the Hospital, such as use of the operating and recovery rooms, anesthesia, dressings, medications, whole blood and blood products, oxygen, X-ray, and laboratory Services during the period of inpatient hospitalization. (Personal items such as guest meals, slippers, etc., are not covered.)

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

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

4.6.2 Skilled Nursing Facility

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

4.6.3 Inpatient Rehabilitative Care

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

4.6.4 Inpatient Habilitative Care

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

4.6.5 Observation Care

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

4.7 OUTPATIENT SERVICES

4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy

Benefits are provided as shown in the Benefit Summary and include Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider’s office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, and therapeutic procedures as ordered by your Qualified Practitioner. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. The Plan may require that you obtain a second opinion for some 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 3.5.

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

4.7.2 Outpatient Rehabilitative Services

Benefits are included for outpatient physical, occupational and speech therapy Covered Services provided by a physician or licensed/registered therapist, as stated in the Benefit Summary, to restore or improve lost function following illness or injury.

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). All Services are subject to review for Medical Necessity. Limits do not apply to Mental Health Covered Services. (See section 4.6.3 for coverage of Inpatient Rehabilitative Services.)

Covered Services under this benefit do NOT include:

- Chiropractic adjustments and manipulations of any spinal or bodily area;
- Exercise programs;
- Rolfing, polarity therapy and similar therapies; and
- Rehabilitation services provided under an authorized home health care plan as stated in section 4.11.

4.7.3 Outpatient Habilitative Services

Coverage is provided, as shown in the Benefit Summary, for Medically Necessary outpatient habilitative Services. All Services are subject to review for Medical Necessity and must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. Coverage is provided at the same benefit level as Outpatient Rehabilitative Care listed in your Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 4.6.4 for coverage of Inpatient Habilitative Services.)

4.8 MATERNITY SERVICES

Your benefits include coverage for comprehensive maternity care.

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

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

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**.

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

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

PLEASE NOTE: Newborn nursery care, newborn nurse home visits, and any other Services provided to your newborn are covered only when the newborn child is properly enrolled under this Plan within time frames outlined in Newborn Eligibility and Enrollment, section 8.2.4.

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

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

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

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

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

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

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

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

4.9.1 Medical Supplies (including Diabetes Supplies)

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

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

4.9.2 Medical Appliances

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

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

4.9.3 Prosthetic and Orthotic Devices

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

4.9.4 Durable Medical Equipment (DME)

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

4.10 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

This Plan complies with Oregon and Federal Mental Health Parity.

4.10.1 Mental Health Services

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

Covered Services include diagnostic evaluation, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services. All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services must be Prior Authorized as specified in section 3.5.

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

4.10.2 Applied Behavior Analysis

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

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

Exclusions to ABA Services:

- Services provided by a family or household member;
- Services that are custodial in nature, or that constitute marital, family, or training services;
- Services that are educational or correctional that are provided by a school or halfway house or received as part of an 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.

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

4.10.3 Substance Abuse Services

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

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

Prior Authorization is required for all inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services, as specified in section 3.5.

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

In an emergency situation, go directly to a Hospital emergency room. You do not need Prior Authorization for emergency treatment; however, 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.

4.11 HOME HEALTH CARE AND HOSPICE CARE

4.11.1 Home Health Care

Benefits for home health care Covered Services are shown in the Benefit Summary and 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.

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

Home health care will not be reimbursed unless your Qualified Practitioner certifies that the home health care Services will be provided or coordinated by a state-licensed or Medicare-certified Home Health 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;
3. Charges for supervision of Home Health Providers; or
4. Services that consist principally of Custodial Care including, but not limited to, care for senile deterioration, mental deficiency, mental illness, developmental disability or care of a chronic or congenital condition on a long-term basis.

4.11.2 Hospice Care

Benefits are included for hospice care as shown in the Benefit Summary and as stated in this section. In addition, the following criteria must be met:

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

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

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

Respite care is not covered.

4.12 OTHER COVERED SERVICES

4.12.1 Genetic Testing and Counseling Services

Genetic testing and counseling are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical

interventions and solutions that are corrective or therapeutic in nature. Genetic testing requires Prior Authorization as shown in section 3.5.

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

4.12.2 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 4.9.1.

4.12.3 Podiatry/Foot Services

Benefits include Covered Services of a podiatrist or other Qualified Practitioner and are provided as shown in the Physician/Provider Services section of the Benefit Summary. Covered Services include, but are not limited to, the fitting and follow up exam for removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are covered as stated in section 4.9.2 (Medical Appliances). Covered Services do not include routine foot care and the removal of corns or calluses, unless you have diabetes.

4.12.4 Reconstructive Surgery

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

4.12.5 Reconstructive Breast Surgery

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

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

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

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

4.12.6 Restoration of Head/Facial Structures; Limited Dental Services

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

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

Exclusions that apply to Covered Services include:

- Cosmetic Services;
- Services rendered to improve a condition that falls within the normal range of such conditions;
- Routine Orthodontia;
- Services to treat tooth decay, periodontal conditions and deficiencies in dental hygiene;
- Removal of impacted teeth;
- The making or repairing of dentures;
- Orthognathic surgery to treat developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth; and
- Services to treat temporomandibular joint syndrome, including orthognathic surgery, except as provided in 4.12.7.

<u>Outpatient Hospitalization and Anesthesia for Limited Dental Services</u>

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.

4.12.7 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 4.9.2(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.

4.12.8 Self-Administered Chemotherapy

Self-administered chemotherapy agents, including oral medications and injectable medications, are covered when received from a Participating retail or specialty Pharmacy.

Self-administered chemotherapy is covered under your Outpatient Chemotherapy benefit. Self-administered chemotherapy is covered under your Prescription Drug benefit when that coverage results in a lower out-of-pocket expense to the Member (See section 4.14).

4.12.9 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.

4.12.10 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.

4.12.11 Gender Dysphoria

Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. Surgical Treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and

must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for a list of services requiring Prior Authorization.

4.12.12 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.

4.12.13 Hearing Loss Services

Definitions:

Cochlear Implant

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

Hearing Aid

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

Covered Services:

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

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

Cochlear implants:

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

Hearing aids & related accessories:

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

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.

Hearing Assistance Technology:

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

Limits to Hearing Loss Services

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

4.12.14 Wigs

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

4.12.15 Biofeedback

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

4.13 HUMAN ORGAN/TISSUE TRANSPLANTS

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

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

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

4.13.1 Covered Services

Covered Services for transplants are limited to Services that:

1. Are determined by Providence Health Plan to be Medically Necessary and medically appropriate according to national standards of care;

2. Are provided at a facility approved by us or under contract with 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 lifetime benefit maximum for transportation, food and lodging. Food and lodging is subject to a $150 per diem. Per diem expenses apply to the $5,000 travel expenses lifetime 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.

4.13.2 Benefits for Transplant Facility Services Provided to the Organ Recipient

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

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

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

4.13.3 Benefits for Outpatient Medications

Outpatient prescription medications for transplant-related Services, including anti-rejection (immunosuppressive) drugs, are not eligible for reimbursement under the medical benefits of this Plan. Benefits for outpatient prescription drugs are provided under this Plan's Prescription Drug Benefit and those benefits are subject to the terms and limitations of that Benefit.

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

Benefits for physician/provider Services are provided as shown in the Benefit Summary. The Member/recipient is responsible for the 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.

4.13.5 Transplant Prior Authorization

(See also section 3.5.)

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.

4.13.6 Transplant Exclusions

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

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

4.14 PRESCRIPTION DRUG BENEFIT

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

Prescription Drug Definition

The following are considered "Prescription Drugs":

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

4.14.1 Using Your Prescription Drug Benefit

Your Prescription Drug Benefit requires that you fill your prescriptions at a Participating Pharmacy.

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

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

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

- Please present your Member ID Card to the Participating Pharmacy at the time you request Services. If you have misplaced or do not have your Member ID Card with you, please ask your pharmacist to call us.
- All covered Services are subject to the Copayments or Coinsurance listed in your Benefit Summary.
- If you choose a brand-name drug when a generic-equivalent is available, any difference in cost for Prescription Drug Covered Services will not apply to your Calendar Year Deductibles and Out-of-Pocket Maximums.
- The amount paid by a manufacturer discount and/or copay assistance programs for a brand-name drug when a generic equivalent is available may not apply towards 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 Benefit or need assistance processing your prescription.

- Copayments or Coinsurance are due at the time of purchase. If the cost of your Prescription Drug is less than your Copayment, you will only be charged the cost of the Prescription Drug.
- You may be assessed multiple Copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- You may purchase up to a 90-day supply of each maintenance 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 www.ProvidenceHealthPlan.com. (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 your Medical Supplies benefits, limitations and Copayments and/or Coinsurances. See section 4.9.1 and your Benefit Summary. Diabetes supplies do not include insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.9.4.
- Self-administered chemotherapy drugs are covered under section 4.12.8 unless the benefits under this Prescription Drug Benefit allow for a lower out-of-pocket cost to you.
- Injectable medications received in your Provider's office are covered under section 4.3.5.
- Infusions, including infused medications, received at Outpatient Facilities are covered under section 4.7.1.
- Some prescription drugs require Prior Authorization or an exception to the Formulary in order to be covered. These may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in the Providence Health Plan Prescription Drug Formulary available on our website at www.ProvidenceHealthPlan.com 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.

4.14.2 Use of Out-of-Network Pharmacies

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

To request reimbursement, you will need to fill out and submit to Providence Health Plan a Prescription Drug Reimbursement form. This form is available on our website or by contacting Customer Service. When you submit the completed Prescription Drug

Reimbursement form, include any itemized pharmacy receipts, along with an explanation as to why you used an Out-of-. 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 our Participating Pharmacy contracted rates, less your Copayment or Coinsurance if applicable. 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.

4.14.3 Prescription Drug Formulary

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

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

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

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

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

4.14.4 Prescription Drugs

Generic and Brand-Name Prescription Drugs

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

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

Maximum, and you will continue to be responsible for the difference in cost after your Out-of-Pocket Maximum is met.

Affordable Care Act Preventive Drugs

Affordable Care Act (ACA) preventive drugs are medications, including contraceptives, which are listed in our Formulary and are covered at no cost when received from Participating Pharmacies as required by the ACA. 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.

4.14.5 Prescription Drug Quantity

Prescription dispensing limits, including refills, are as follows:

1. Topicals, up to 60 grams;
2. Liquids, up to eight ounces;
3. Tablets or capsules, up to 100 dosage units;
4. Multi-use or unit-of-use, up to one container or package; as prescribed, not to exceed a 30-consecutive-day supply, whichever is less;
5. FDA-approved women's prescription contraceptives: up to 3-months initial dispensing, then up to 12-months subsequent dispensing at any 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 our Oregon Region Pharmacy and Therapeutics Committee. Prior Authorization is required for amounts exceeding any applicable medication dispensing limits.

4.14.6 Participating Mail-Order and Preferred Retail Pharmacies

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

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

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

4.14.7 Prescription Drug Limitations

Prescription drug limitations are as follows:

1. All drugs must be Food and Drug Administration (FDA) approved, Medically Necessary and require by law a prescription to dispense. Not all FDA-approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety

and Medical Necessity within 12 months after the drug becomes available on the market for Formulary consideration.

2. Certain drugs require Prior Authorization for Medical Necessity, place of therapy, length of therapy, step therapy, number of doses or dispensing limits. Step therapy uses our pharmacy claims history to confirm if certain drugs have been tried first by a Member. If a drug has not been tried first, cannot be tried first, or if the drug history is not available, Prior Authorization is required. For some drugs, Providence Health Plan limit the amount of the drug the Plan will cover. You or your Qualified Practitioner can contact Providence Health Plan directly to request Prior Authorization. If you have questions regarding a specific drug, please call Customer Service.
3. Specialty drugs are injectable, infused, oral, topical, or inhaled therapies that often require specialized delivery, handling, monitoring and administration and are generally high cost. These drugs must be purchased through a Providence Health Plan designated specialty pharmacy. Due to the nature of these medications, specialty drugs are limited to a 30-day supply. Specialty drugs are listed in the Formulary. In rare circumstances specialty medications may be filled for greater than a 30-day supply; in these cases, additional specialty cost share(s) may apply.
4. Self-injectable medications are only covered when they are being self-administered and labeled by the FDA for self-administration; in some cases, a Prior Authorization may be required for the drug. Documentation of self-administration may also be required. Drugs labeled for self-administration that are being administered by a provider will fall to the Member's medical benefit.
5. Medications, drugs or hormones prescribed to stimulate growth are not covered, except when there is a laboratory-confirmed diagnosis of growth hormone deficiency for children through 18 years of age and when prescribed for the treatment of documented pituitary destruction in adults.
6. 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.
7. In accordance with the ACA, your Plan provides coverage in full of certain medications, including contraceptives, when these medications are purchased from Participating Pharmacies. Not all preventive medications are required to be covered in full by the ACA. Medications in this category may be subject to medical management techniques to determine frequency, method, treatment, or setting. Brand medications for which a generic is available will not be covered in full unless the Member has received Prior Authorization from Providence Health Plan.
8. Vacation supply medication refill overrides are limited to a 30-day supply once per Calendar Year, unless otherwise provided under your Plan. Additional exceptions may be granted on a case-by-case basis.
9. A 30 day supply medication refill override will be granted if you are out of medication and have not yet received your drugs from a participating mail order pharmacy.

4.14.8 Prescription Drug 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 4.3.5);
2. Amphetamines and amphetamine derivatives except when used in the treatment of narcolepsy or attention deficit and/or hyperactivity disorder in children and adults;
3. Drugs prescribed that do not relate to the prevention or treatment of a covered illness or injury;
4. Drugs used for the treatment of fertility/infertility;
5. Fluoride, for Members over 16 years of age;
6. Drugs that are not provided in accordance with our formulary management program or are not provided according to our medical policy;
7. Drugs used in the treatment of fungal nail conditions;
8. 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;
9. Prescription drugs, including prescription combination drugs, that contain OTC products or are available in an OTC therapeutically similar form;
10. 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;
11. Drugs, which may include prescription combination drugs, placed on a prescription-only status as required by state or local law;
12. Replacement of lost or stolen medication;
13. Drugs or medicines used to treat sexual dysfunction (this exclusion does not apply to Mental Health Covered Services);
14. Drugs used in the treatment of drug-induced fatigue, general fatigue and idiopathic hypersomnia;
15. Drugs dispensed or compounded by a pharmacist that do not have at least one FDA-approved medication in therapeutic amount;
16. Drugs used for weight loss or for cosmetic purposes;
17. 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);
18. Prenatal vitamins that contain docosahexaenoic acid (DHA);
19. Drugs that are not FDA-approved or are designated as "less than effective" by the FDA (also known as "DESI" drugs);
20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC; and
21. 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.

4.14.9 Prescription Drug Disclaimer

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

5. EXCLUSIONS

In addition to those Services listed as not covered in section 4, 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;
- Are not a Covered Service or relate to complications resulting from a Non-Covered Service, except for Services provided as Emergency Care as described in section 4.5;
- Are not furnished by a Qualified Practitioner or Qualified Treatment Facility;
- Are provided by or payable under any health plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law;
- Are provided while you are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies, except to the extent provided by 38 U.S.C. § 1729 as it relates to non-military Services provided at a Veterans Administration Hospital or facility;
- Are provided while you are in the custody of any law enforcement authorities or while incarcerated, except as provided in section 3.3;
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos, books and educational programs to which drivers are referred by the judicial system, and volunteer mutual support groups;
- Are provided to yield primarily educational outcomes, except as otherwise covered under the Preventive Services benefit described in section 4.1. An outcome is "primarily educational" if the outcome's fundamental, first, or principal character is to provide you with enduring knowledge, skill, or competence through a process of repetitive positive reinforcement over an extended length of time. An outcome is "enduring" if long-lasting or permanent;
- Are performed in association with a Service that is not covered under this Plan, except Emergency Services;
- Are provided for any injury or illness that is sustained by any Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the Member. This exclusion also applies to injuries and illnesses that are the subject of a claim settlement 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. This exclusion also applies to charges applied to the deductible of such contract or insurance. Any benefits or Services provided under this Plan that are subject to this exclusion are provided solely to assist you and such assistance does not waive our right to reimbursement or subrogation as specified in section 6.3. This exclusion also applies to Services and supplies after you have received proceeds from a settlement as specified in section 6.3.3;
- Are provided in an institution that specializes in treatment of developmental disabilities, except as provided in section 4.10.2;
- Are provided for treatment or testing required by a third party or court of law which is not Medically Necessary;
- Are Experimental/Investigational;
- Are determined by us not to be Medically Necessary for diagnosis and treatment of an injury or illness;
- Are received by a Member under the Oregon Death with Dignity Act;
- Have not been Prior Authorized as required by this Plan; and
- Relate to any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member, if such Member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony or misdemeanor punishable by up to a year's imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or mental health condition);

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 4.13;
- Services for Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment (DME), except as described in section 4.9;
- Charges for Services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to, air conditioners, air purifiers, vacuum cleaners, motorized transportation equipment, escalators, elevators, tanning beds, ramps, waterbeds, hypoallergenic mattresses, cervical pillows, swimming pools, whirlpools, spas, exercise equipment, gravity lumbar reduction chairs, home blood pressure kits, personal computers and related equipment or other similar items or equipment;
- Physical therapy and rehabilitative Services, except as provided in sections 4.6.3 and 4.7.2;

- "Telephone visits" by a physician or "environment intervention" or "consultation" by telephone for which a charge is made to the patient, except as provided in section 4.3.2
- "Get acquainted" visits without physical assessment or diagnostic or therapeutic intervention provided and online treatment sessions;
- Missed appointments;
- Non-emergency medical transportation;
- Allergy shots and allergy serums, except as provided in section 4.3.5;
- All Services and supplies related to the treatment of obesity or morbid obesity, except as provided in section 4.1.6;
- Services for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas, except as provided in section 4.1.6;
- Transportation or travel time, food, lodging accommodations and communication expenses except as provided in sections 3.6 and 4.13 and with our prior approval;
- Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
- Biofeedback, except as provided in section 4.12.15;
- Massage therapy;
- Thermography;
- Homeopathic procedures;
- Comprehensive digestive stool analysis, cytotoxic food allergy test, dark-field examination for toxicity or parasites, EAV and electronic tests for diagnosis and allergy, fecal transient and retention time, Henshaw test, intestinal permeability, Loomis 24-hour urine nutrient/enzyme analysis, melatonin biorhythm challenge, salivary caffeine clearance, sulfate/creatinine ratio, urinary sodium benzoate, urine/saliva pH, tryptophan load test, and zinc tolerance test;
- Chiropractic manipulation and acupuncture, except as provided in sections 4.12.9 and 4.12.10;
- Light therapy for seasonal affective disorder, including equipment;
- Any vitamins, dietary supplements, and other non-prescription supplements, except as required by federal or Oregon state law;
- Services for genetic testing are excluded, except as provided in section 4.12.1. Genetic testing is not covered for screening, to diagnose carrier states, or for informational purposes in the absence of disease;
- Services to modify the use of tobacco and nicotine, except as provided in section 4.1.8 or when provided as Extra Values or Discounts (see our website at www.ProvidenceHealthPlan.com), where available;
- Cosmetic Services including supplies and drugs, except as approved by us and described in section 4;
- Services, including routine physical examination, immunizations and vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel;
- Non-sterile examination gloves;
- Sales taxes, handling fees and similar surcharges, as explained in the definition of UCR; and

- Air ambulance transportation for non-emergency situations is not covered, except as provided in section 4.5.2.
- Treatments that do not meet the national standards for Mental Health and Substance Abuse professional practice.
- Services provided under a court order or as a condition of parole or probation or instead of incarceration which are not Medically Necessary;
- Personal growth services such as assertiveness training or consciousness raising;
- School counseling and support services, peer support services, tutor and mentor services; independent living services, household management training, and wraparound services that are provided by a school or halfway house and received as part of an 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;
- Speech therapy, physical therapy and occupational therapy services provided in connection with treatment of psychosocial speech delay, learning disorders, including mental retardation and motor skill disorders, and educational speech delay including delayed language development (except as provided in sections 4.6.3 and 4.7.2);
- Counseling related to family, marriage, sex and career including, but not limited to, counseling for adoption, custody, family planning or pregnancy, in the absence of a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis;
- Neurological Services and tests including, but not limited to, EEGs, PET, CT, MRA and MRI imaging Services, and beam scans (except as provided in section 4.4.1);
- Vocational, pastoral or spiritual counseling;
- Viscosupplementation (i.e., hyaluronic acid/hyaluronan injection);
- All Direct-to-Consumer testing products; and
- Dance, poetry, music or art therapy, except as part of an approved treatment program.

Exclusions that apply to Provider Services:

- Services of homeopaths; faith healers; or lay, unlicensed direct entry, and certified professional midwives; and
- Services of any unlicensed providers.

Exclusions that apply to Reproductive Services:

- All services related to sexual disorders or dysfunctions regardless of gender or cause (this exclusion does not apply to Mental Health Covered Services);
- All of the following services:
    - All services related to surrogate parenting, except Maternity Services as described in section 4.8;
    - All services related to in vitro fertilization, including charges for egg/semen harvesting and storage;

- All services related to artificial insemination, including charges for semen harvesting and storage;
- All services and prescription drugs related to fertility preservation;
- Diagnostic testing and associated office visits to determine the cause of infertility;
- All of the following services when provided for the sole purpose of diagnosing and treating an infertile state or artificial reproduction:
  - Physical examination;
  - Related laboratory testing;
  - Instruction;
  - Medical and surgical procedures, such as hysterosalpingogram, laparoscopy, or pelvic ultrasound; and
  - Related supplies and prescriptions.

For the purpose of this exclusion:

- Infertility or infertile means the failure to become pregnant after a year of unprotected intercourse or the failure to carry a pregnancy to term as evidenced by three consecutive spontaneous abortions.
- Artificial reproduction means the creation of new life other than by the natural means.

- Termination of pregnancy, unless there is a severe threat to the mother, or if the life of the fetus cannot be sustained;
- Reversal of voluntary sterilization;
- Male condoms and other over-the-counter birth control products for men; 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 4.1.1, 4.1.5, 4.1.9, 4.5.3 and 4.9.2;
- Orthoptics and vision training; and
- Services for routine eye care and vision care, vision exams/screenings, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in sections 4.1.1, 4.1.5, 4.5.3 and 4.9.2.

Exclusions that apply to Hearing Services:

- Replacement of lost or broken hearing aids are generally not covered, except for one time if a loss or damage claim is made within the first year of purchase;
- Repair of hearing aids outside of the warranty period are not covered. Repair needs during your warranty period should be discussed with your provider;
- Hearing aids prescribed and ordered prior to coverage, or prescribed or ordered after termination of coverage, whichever occurs first; and
- Hearing aids, hearing therapies and/or devices, except as provided in section 4.12.13.

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 us and described in sections 4.12.6;
- Services for orthognathic surgery, except as approved by us and described in section 4.12.6;
- Services to treat temporomandibular joint syndrome (TMJ), except as provided in section 4.12.7; and
- Dentures and orthodontia, except as provided in sections 4.12.6.

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 4.9.2.

Exclusions that apply to Prescription Drugs, Medicines and Devices:

- In addition to the exclusions listed in section 4.14.8; 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.

6. 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.

6.1 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 is not a bill. An EOB explains how Providence Health Plan processed your claim, and will assist you in paying the appropriate Member responsibility to your provider. Copayment or Coinsurance amounts, Deductible amounts, services or amounts not covered and general information about our processing of your claim are explained on an EOB.

Time Frames for Processing Claims

If 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 if 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, you will be sent a separate request for the information and you will have 45 days to submit the additional information. Once the additional information from you 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 additional information is needed to process the request, Providence Health Plan will provide written notice to the Member and the provider within two business days of receiving the Prior Authorization request. The Member and the provider will have 15 days to submit the additional information. Within two business days of receipt of the additional information, Providence Health Plan will complete 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 24 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.

6.1.1 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 (i.e., a Coordinated Care Organization) will be made in accordance with ORS 743B.470, which establishes payment requirements for claims submitted by the Oregon state Medicaid agency.

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

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

6.1.2 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.

6.2 COORDINATION OF BENEFITS

This Coordination of Benefits (COB) section applies when a Member has health care coverage under more than one Plan. The term "Plan" is defined below for the purposes of this COB section. The order of benefit determination rules 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.

6.2.1 Definitions Relating to Coordination of Benefits

Plan

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

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

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

This Plan

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

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

When This Plan is primary, Providence Health Plan determines payment for benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, Providence Health Plan determines benefits after those of another Plan and

may reduce the benefits payable 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.

6.2.2 Order of Benefit Determination Rules

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

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

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

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

coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

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

iv. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the Dependent child are as follows:

- The Plan covering the Custodial parent, first;
- The Plan covering the spouse of the Custodial parent, second;
- The Plan covering the non-custodial parent, third; and then
- The Plan covering the Dependent spouse of the non-custodial parent, last.

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

d) For a Dependent child:

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

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

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

agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

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

6.2.3 Effect on the Benefits of This Plan

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

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

6.2.4 Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply this COB section and to determine benefits payable under This Plan and other Plans. Providence Health Plan may get the facts needed from, or give them to, other organizations or persons for the purpose of applying this section and determining benefits payable under This Plan and other Plans covering a Member claiming benefits. Providence Health Plan 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 Providence Health Plan needs to apply this section and determine benefits payable.

6.2.5 Facility of Payment

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

6.2.6 Right of Recovery

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

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

6.2.7 Coordination with Medicare

In all cases, coordination of benefits with Medicare will conform with federal statutes and regulations. Medicare means Title XVIII of the Social Security Act, as enacted or amended. Medicare eligibility and how This Plan determines benefit limits 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.

6.3 THIRD-PARTY LIABILITY/SUBROGATION

The following provisions will apply when you or any other Member has received Services for a condition for which one or more third parties may be responsible. "Third party" means any person other than the Member (the first party to the provisions of this Plan), 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 us 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 9.4. 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 the Plan under these provisions.

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

Third-party liability refers to claims that are in whole or part the responsibility of someone besides the 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, the Plan 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 the Plan makes claim payments 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 the 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, the Plan is 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 has a security interest in and lien upon any recovery to the extent of the amount of benefits paid by the Plan and for the Plan's expenses in obtaining a recovery. If the Member should either decline to pursue a claim against a third party that the Plan believes is warranted or refuse to cooperate with the Plan in any third party claim that the Member does pursue, the Plan has 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, the Plan needs 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 Providence Health Plan office. A Providence Health Plan employee who specializes in third-party liability/subrogation can discuss these procedures and what you or the Member needs to do.

6.3.2 Proceeds of Settlement or Recovery

Subject to paragraph 6.3.4 below, if for any reason 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 the Plan 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 the Plan for the condition, calculated using the 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 the Plan's first priority to this repayment and assigns to us 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 the Plan. 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 the Plan directly from the settlement or recovery in the amount provided by this section.

The Member must complete the Plan's trust agreement, by which the Member and any Member's attorney (or other agent) must confirm the obligation to reimburse the Plan 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 the Plan. The agreement must remain in effect and the Plan 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 the Plan to exercise the Plan's rights under this section, it serves as a reminder to the Member and directly obligates any Member's attorney to act in accord with the Plan's rights.

6.3.3 Suspension of Benefits and Reimbursement

Subject to paragraph 6.3.4 below, after the Member has received proceeds of a settlement or recovery from the third party, the Member is responsible for payment of all medical expenses for the continuing treatment of the illness or injury that 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 the Plan as required by this section, the Plan is entitled to offset future benefits otherwise payable under this Plan, or under any future contract or plan with Clackamas County, 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 the 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 the 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 the Plan has not approved in advance. In no event shall the amount reimbursed to the Plan be less than the maximum permitted by law.

6.3.4 Special Rules for Motor Vehicle Accident Cases

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

Before the Plan will be entitled to recover 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.

7. PROBLEM RESOLUTION

7.1 INFORMAL PROBLEM RESOLUTION

All employees of Providence Health Plan share responsibility for assuring Member satisfaction. If you have a problem or concern about your coverage, including benefits or Services by In-Network Providers or payment for Services by Out-of-Network Providers, please ask for Providence Health Plan's 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, Providence Health Plan will make efforts to accommodate your requirements. Please contact Customer Service for help with whatever special needs you may have.

7.2 MEMBER GRIEVANCE AND APPEAL

Definitions:

Adverse Benefit Determination

An Adverse Benefit Determination means a:

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

Appeal

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

Authorized Representative

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

Concurrent Care

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

Grievance

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

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

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

7.2.1 Your Grievance and Appeal Rights

If you disagree with Providence Health Plan's decision about your medical bills or health care services, you have the right to an 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 Providence Health Plan will consider that information in the 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 by. 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 Providence Health Plan's decision on your Grievance or Appeal of a denied Prior Authorization or Concurrent Care request, you may request an expedited review by calling your 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, you will be notified of the 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 reconsideration of the decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. Providence Health Plan will then notify you of the reconsideration decision within 24 hours of receiving your request.

7.2.2 Internal Grievance or Appeal

You must file your internal Grievance or Appeal within 180 days of the date on the notice of the initial Adverse Benefit Determination, or that initial determination will become final. Please advise Providence Health Plan of any additional information that you want considered in 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 for the review process. Your Grievance or Appeal will be reviewed by Providence Health Plan staff not involved in the initial determination. You may present your case in writing. Once a final determination is made you will be sent a written explanation of the decision.

7.2.3 External Review

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

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

The Plan pays for all costs for the handling of external review cases and Providence Health Plan administers these provisions in accordance with the insurance laws and regulations of

the State of Oregon. **If we do not comply with the IRO decision, you have the right to sue us under applicable Oregon law.**

7.2.4 How to Submit Grievances or Appeals and Request Appeal Documents

To submit your Grievance or Appeal or requests for External Review, you may contact Customer Service at 503-574-7500 or 800-878-4445. If you are hearing impaired and use a Teletype (TTY) Device, please call the TTY line at 711. Written Grievances or Appeals should be sent to:

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

You may fax your Grievance or Appeal 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

If your plan is governed by ERISA, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). If your plan is not governed by ERISA, you may contact the Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789.

8. 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 and your Employer must provide Providence Health Plan with evidence of eligibility as requested.

8.1 EMPLOYEE ELIGIBILITY AND ENROLLMENT

8.1.1 Employee Eligibility Date

An employee is eligible for coverage as specified in the Eligible Employee definition.

8.1.2 Employee Effective Date

Coverage begins for an Eligible Employee as specified in the Effective Date of Coverage definition.

8.1.3 Employee Enrollment

The Eligible Employee must enroll on forms (paper or electronic) provided and/or accepted by Clackamas County. To obtain coverage, an Eligible Employee must enroll within 30 days to enroll after becoming eligible. An enrolled Eligible Employee is referred to as the Subscriber.

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.

In certain situations, you and/or your Eligible Family Dependents may qualify to enroll during a special enrollment period. See section 8.3 for additional information.

8.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

8.2.1 Eligibility Date

Coverage begins for each Eligible Family Dependent on:

1. The Effective Date of Coverage for the Subscriber if the individual is an Eligible Family Dependent on that date;
2. For any Eligible Family Dependents acquired on the date of the Subscriber's marriage, on the first day of the calendar month following receipt of the enrollment request, within 60 days of the Subscriber's marriage;
3. The date of birth of the biological child of the Subscriber or Spouse;
4. The date a child is placed with the Subscriber or Spouse for the purpose of adoption by the Subscriber or Spouse;
5. The date the Subscriber or Spouse is required to provide health coverage to a child under a qualified medical child support court or administrative order; or
6. The date on which legal guardianship status begins.

8.2.2 Additional Requirements for Eligible Family Dependent Coverage

An Eligible Employee may cover Eligible Family Dependents ONLY if the Eligible Employee is also covered, and Clackamas County receives the completed enrollment form requesting Dependent coverage.

8.2.3 Eligible Family Dependent Enrollment

You must enroll Eligible Family Dependents on forms provided and/or accepted by Clackamas County. No Eligible Family Dependent will become a Member until Clackamas County approves that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within 30 after becoming eligible as indicated in section 8.2.1 (see section 8.2.4 regarding newborn and adopted children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 8.3.

8.2.4 Newborn Eligibility and Enrollment

A newborn or adopted child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption as long as enrollment occurs within 60 days from birth or placement and additional Premium, if any, is paid to Clackamas County. 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 8.2.3 and 8.3.

8.2.5 Open Enrollment Period

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

8.2.6 Changes in Eligibility

When an eligibility change occurs, you need to make sure Clackamas County is notified of the change. Address changes can be made by contacting Clackamas County Benefits & Wellness.

For the following changes, you, as the Subscriber, must obtain an enrollment form from Clackamas County's benefit office. You need to submit this form to your Employer for you and all your Eligible Family Dependents when:

- You marry and wish to enroll your new Spouse;
- A Dependent's limiting age occurs; or
- You or one of your Dependents has a legal name change.

If you have questions regarding eligibility changes, please contact Clackamas County Benefits & Wellness.

8.2.7 Members No Longer Eligible for Coverage

If you divorce or are legally separated, your Spouse is no longer eligible for coverage as a Dependent. You must disenroll your Spouse as a Dependent from your Plan at the time the divorce or legal separation is final. Your Spouse's children will be able to continue coverage under the Plan so long as the children continue to qualify as your Eligible Family Dependents.

You must inform Clackamas County of these changes by completing a new enrollment form. Check with Clackamas County's benefits office or contact Customer Service 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 section 10. Ask Clackamas County or call Customer Service for continuation coverage eligibility information.

8.3 SPECIAL ENROLLMENT PERIODS

If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your Spouse) during a previous enrollment period (as stated in sections 8.1 and 8.2), you may be eligible to enroll yourself or the Eligible Family Dependent during a "special enrollment period" provided that you request enrollment within 60 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
- Enroll in any benefit option offered by the Employer for which the Subscriber and Eligible Family Dependent is eligible.

8.3.1 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, the Plan 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 the Plan 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 benefits; and the individual applies for coverage under this Plan within 60 days after the claim is denied.

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

8.3.2 New 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, birth, adoption or placement for adoption; the Plan 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 60 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.

Effective Date:

- in the case of marriage, on the first day of the calendar month following Clackamas County's receipt of the enrollment request, or on an earlier date as agreed to by Clackamas County; 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.

8.3.3 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 or minor child under your Health Benefit Plan, the Plan 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 60 days after the issuance of the court order.

Effective Date: The date specified in the court order.

8.3.4 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 arrangement, the Plan 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.

8.4 LEAVE OF ABSENCE AND LAYOFFS

A Subscriber on leave of absence or layoff status may continue to be covered under this Plan as though actively at work for a period of time, if any, as stated in the Eligible Employee definition. An Employee who returns to work as an Eligible Employee after coverage has lapsed must re-enroll for coverage as specified in section 8.1.3.

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), is administered in accordance with those Acts and this Summary Plan Description.

9. TERMINATION OF MEMBER COVERAGE

9.1 TERMINATION DATES

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 Clackamas County;
3. The last day of the coverage period in which a Subscriber no longer qualifies as a Subscriber, as stated in the Summary Plan Description;
4. The date a Member enters full-time military, naval or air service, except as provided under federal USERRA requirements;
5. The last day of the coverage period in which a Subscriber retires;
6. 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;
7. For a Family Member, the date the Subscriber's coverage terminates;
8. For a Family Member, the last day of the month in which the individual no longer qualifies as an Eligible Family Dependent;
9. For any benefit, the date the benefit is deleted from this Plan;
10. For a Member, the date of disenrollment from this Plan as described in section 9.4;
11. For a Member, the date any fraudulent information is provided; or
12. For a Member, the date we discover any breach of contractual duties, conditions or warranties, as determined by us.
13. For a Subscriber that is a Non-Medicare Eligible Early Retiree, the last day of the month in which the Retiree becomes eligible for Medicare.

You and the Employer are responsible for advising Clackamas County 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 Clackamas County.

See section 7, Problem Resolution, for your Grievance and Appeal rights.

9.2 TERMINATION AND RESCISSION OF COVERAGE DUE TO FRAUD OR ABUSE

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

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

9.3 NON-LIABILITY AFTER TERMINATION

Upon termination of this Plan, Clackamas County shall have no further liability beyond the effective date of the termination unless the Member continues, without lapse of membership, under another Clackamas County plan.

9.4 DISENROLLMENT FROM THIS PLAN

"Disenrollment" means that your coverage under this Plan is terminated 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 Clackamas County or Providence Health Plan employees; or
4. You have allowed a non-Member to use your Member ID Card to obtain Services.

9.5 NOTICE OF CREDITABLE COVERAGE

Providence Health Plan will provide upon request written certification of the Member's period of Creditable Coverage when:

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

9.6 CLACKAMAS COUNTY'S RIGHT TO TERMINATE OR AMEND PLAN

Clackamas County 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 Clackamas County.

10. 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 and which are generally outlined below. Please contact Clackamas County as soon as possible for details if you think you may qualify for group COBRA or state continuation coverage.

10.1 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.

10.1.1 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.

10.1.2 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.

10.1.3 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 who is properly enrolled under the terms of this Plan during the COBRA continuation period will be a qualified beneficiary.

10.1.4 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 Clackamas County 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 Clackamas County 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.

10.1.5 Type of COBRA Continuation Coverage

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

10.1.6 COBRA Election Rights

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

10.1.7 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 Clackamas County 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.

10.1.8 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 their 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 Clackamas County 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 Dependent child 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.

10.1.9 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.

10.1.10 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/.

10.1.11 When COBRA Continuation Coverage Ends

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

- Clackamas County 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;
- 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.

11. MEMBER RIGHTS AND RESPONSIBILITIES

11.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES

As a Member of Providence Health Plan, you should know what to expect from Providence Health Plan, as well as what Providence Health Plan asks from you. Nobody knows more about your health than you and your doctor. Providence Health Plan takes 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. Providence Health Plan wants you to have a positive experience, and 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, the providers, and the benefits and Services you have available to you as a Member.
- Receive information that helps you select a Qualified Practitioner whom you trust and with whom you feel comfortable.
- A candid discussion of appropriate or Medically Necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Receive information and clinical guidelines from your health care provider or your health plan that will enable you to make thoughtful decisions about your health care.
- Actively participate in decisions that relate to your health and your medical care through discussions with your health care provider or through written advance directives.
- Have access to medical Services that are appropriate for your needs.
- Express a concern or an Appeal and receive a timely response from Providence Health Plan.
- Have your claims paid accurately and promptly.
- Request a review of any service not approved, and to receive prompt information regarding the outcome.
- Be informed about and make recommendations regarding Providence Health Plan's member rights and responsibilities policy.
- Refuse care from specific providers.

Members have the responsibility to:

- Read and understand the information in and the terms of your Plan. Neither the Plan nor Providence Health Plan will have liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact Customer Service. Providence Health Plan will assist you in understanding and complying with the terms of the Plan.
- Talk openly with your physician or provider, understand your health problem and work toward a relationship built on mutual trust and cooperation.
- Develop mutually agreed upon treatment goals with your Qualified Practitioner, to the degree possible, and follow treatment plans and instructions.
- Supply to the extent possible information Providence Health Plan 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 Customer Service know if you have concerns or if you feel that any of your rights are being compromised, so that Providence Health Plan can act on your behalf.
- Call or write within 180 days of Service if you wish to request a review of Services provided or Appeal a Providence Health Plan decision.
- Notify Customer Service if your address changes.

Providence Health Plan has the responsibility to:

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

11.2 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 Clackamas County's Group Plan, you are entitled to certain rights and protections under Oregon law, which provides that all Plan participants are entitled to:

1. **Receive from Providence Health Plan information maintained about you by your Employer's group plan**
    - You are entitled within 30 days to access to recorded personal information, 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 10.1.
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 7, the Plan offers 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 7.2 of this Summary Plan Description. If the Member elects to seek external review under section 7.2.4, both the Plan and the Member will be bound by the Independent Review Organization (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 7.2.

    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 or an arbitrator, neither party shall under any circumstance be liable to the other for any special, incidental, or consequential damages, or for any tort liability (including any punitive or exemplary damages), in any way related to this Plan.

12. 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.

12.1 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 Clackamas County has determined satisfies the QMSCO standards set forth below.

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

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

12.2 NOTICE UPON RECEIPT OF ORDER

Upon the receipt of any Order, Clackamas County 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.

12.3 NOTICE OF DETERMINATION

Within a reasonable period after its receipt of the Order, Clackamas County 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, the Order will not be considered to be a QMCSO.

12.4 ENROLLMENT OF ALTERNATE RECIPIENT

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

12.5 COST OF COVERAGE

An Alternate Recipient will be treated as having been 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.

12.6 REIMBURSEMENT OF PLAN EXPENSES

Unless the terms of the Order provide otherwise, any payments to be from the Plan as reimbursement for group health expenses paid either by the Alternate Recipient, or by the custodial parent or legal guardian of the Alternate Recipient, will not be paid to the 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.

12.7 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.

12.8 TREATMENT OF NATIONAL MEDICAL SUPPORT NOTICE

If Clackamas County 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 Clackamas County to satisfy the QMCSO standards prescribed above, then the National Notice shall be deemed to be a QMSCO respect to such child.

Clackamas County, upon determining that the National Notice is a QMSCO, 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.

Clackamas County 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.

13. GENERAL PROVISIONS

13.1 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.

13.2 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.

13.3 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.

13.4 FAILURE TO PROVIDE INFORMATION OR PROVIDING INCORRECT OR INCOMPLETE INFORMATION

Members warrant that all information contained in applications, questionnaires, forms, or statements submitted to Clackamas County and to Providence Health Plan to be true, correct, and complete. If a Member willfully fails to provide information required to be provided under this Plan or knowingly provides incorrect or incomplete information, then the Member's rights may be terminated. See section 9.4.

13.5 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.

13.6 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.

13.7 LEGAL ACTION

No civil action may be brought under state or federal law to recover benefits from the Plan until receipt of a final decision under the Member Grievance and Appeal process specified in section 7.2 of the Summary Plan Description, unless the Member's benefits under the Plan are subject to the Employee Retirement Income Security Act (ERISA), in which case the Member is permitted either to bring a civil action under ERISA in federal court after receiving a decision from the First Level of Appeal or to bring such an action after receipt of a final grievance decision. An appeal from a final Grievance decision may lie with an Independent Review Organization (IRO). In the event a right to IRO review exists and the Member elects to seek such review, the IRO decision will be binding and final, as indicated in section 7.2.4. No civil action under ERISA or otherwise 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 7.2. If ERISA does not apply (see section 11.2) the action must be brought in Oregon state court, either in the Member's county of residence or such other county as mutually agreed upon between Member and the Plan. In general, ERISA applies if this is an employer-sponsored plan, other than a government plan or church plan.

13.8 LIMITATIONS AND 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 Clackamas County shall be paid solely in accordance with the terms and provisions of such plan, and nothing in this Plan shall operate or be construed in any way to modify, amend, or affect the terms and provisions of such other plan.

13.9 MEMBER RESPONSIBILITY

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

13.10 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.

13.11 NON-TRANSFERABILITY OF BENEFITS

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

13.12 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 Clackamas County. No shareholder, director, officer, or employee of Clackamas County 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.

13.13 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 Clackamas County nor Providence Health Plan is liable for any claim or demand due to damages arising out of, or in any manner connected with, any injuries suffered by you while receiving such Services.

13.14 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.

13.15 NOTICE

Any notice required of Clackamas County or Providence Health Plan under this Plan shall be deemed to be sufficient if mailed to the Subscriber at the address appearing in 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, P.O. Box 3125, Portland, OR 97208.

13.16 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 6.1.1 regarding timely submission of claims.

13.17 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. PHP'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 Clackamas County and Providence Health Plan.

13.18 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.

13.19 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 our 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.

13.20 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.

13.21 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 Clackamas County to deduct the overpayment from future benefit payments under this Plan.

13.22 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.

13.23 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.

13.24 SUGGESTIONS

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

13.25 VETERANS' RIGHTS

The Plan will provide benefits to employees 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) An employee who takes unpaid military leave, or who separates from the employment of Clackamas County 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 employee's absence for the purpose of performing military service begins; or
    2. The date the employee fails to timely return to employment or reapply for a position with Clackamas County upon the completion of such military service.

13.26 WORKERS' COMPENSATION INSURANCE

This Plan is not in lieu of, and does not affect, any requirement for coverage under any workers' compensation act or similar law.

14. PLAN ADMINISTRATION

14.1 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. 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.

14.2 PLAN INFORMATION

Plan Name: Clackamas County Early Retiree-COBRA-Temporary Employees Open Option Plan
Plan No. 100112
Employer ID No. 936002286

14.3 PLAN DATES

The effective date of the Plan is January 1st and ends on December 31st.

14.4 PLAN SPONSOR INFORMATION

Clackamas County
Benefits & Wellness Division
Public Services Building
2051 Kaen Road, Suite 310
Oregon City, OR 97045
503-655-8459

14.5 ADMINISTRATIVE SERVICES PROVIDED BY

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

14.6 AGENT FOR SERVICE OF LEGAL PROCESS

Clackamas County
Office of County Counsel
2051 Kaen Rd.
Oregon City, OR 97045

14.7 ADMINISTRATIVE SERVICES

The Employer 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.

14.7.1 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.

14.8 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.

14.9 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.

14.10 AMENDMENT OR TERMINATION OF PLAN

14.10.1 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.

14.10.2 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 Chair of the Board of County Commissioners or their designee shall be conclusive evidence of the adoption and effectiveness of the instrument.

14.10.3 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.

14.11 PROTECTED HEALTH INFORMATION

14.11.1 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 PHI obtained from Providence Health Plan 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. Benefit Managers;
    3. Benefit Analysts;
    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.

14.11.2 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 14.11.1(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.

15. DEFINITIONS

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

Adverse Benefit Determination
See section 7.

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

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

Annual
Annual means once per Calendar Year.

Appeal
See section 7.

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

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

Authorized Representative
See section 7.

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

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

Chemical Dependency
Chemical Dependency 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 Abuse does not mean an addiction to, or dependency on tobacco, tobacco products or foods.

Clackamas County
Clackamas County means the entity that is the Sponsor of this Plan.

Clackamas County Early Retiree-COBRA-Temporary Employees Open Option Plan
Clackamas County Early Retiree-COBRA-Temporary Employees Open Option Plan means this Summary Plan Description and includes the provisions of the Benefit Summaries and any Endorsements, amendments and addendums that accompany this document.

Cochlear Implant
See section 4.12.13.

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. Your Coinsurance for a Covered Service is shown in the Benefit Summary and is a percentage of the charges for the Covered Service. Your Coinsurance will usually be less when you receive Covered Services from an In-Network Provider.

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 section 4;
2. Medically Necessary;
3. Not listed as an Exclusion in the Benefit Summary or in sections 4 and 5; 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 3.11.1.

Dependent

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

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 with a member of the same sex; and
    - Has legally registered a Declaration of Domestic Partnership and obtained a Certificate of Registered Domestic Partnership in accordance with Oregon state law.
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 4.3.3).

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

Eligibility Waiting Period
Eligibility Waiting Period means the period of employment, as specified in the Eligible Employee definition, that an otherwise Eligible Employee must complete before coverage will begin under this Plan. The Eligibility Waiting Period will not exceed 90 days. When the Eligibility Waiting Period is 90 days, coverage is effective on the 91st day. If an employee enrolls on a special enrollment date, any period before such special enrollment is not an Eligibility Waiting Period.

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 8.1.
1. Employment Status: On-call, substitute, and seasonal employees are not eligible.
2. Employment Category/Class: Non-Medicare Early Retiree-COBRA-Temporary Employees.
3. Work Hours: Not applicable for Early Retirees or COBRA participants. Temporary Employees: work an average of 30 or more hours during the most recent Affordable Care Act measurement period or are hired with the intent of working more than an average of 30 hours per week for longer than 90 days.
4. Eligibility Waiting Period: Not applicable for Early Retirees or COBRA participants. Temporary Employees: minimum of 60 days.*
   (*Note: Effective July 1, 2021, the Eligibility Waiting Period for Temporary Employees hired on or after this date will be the first of the month following date of hire.)
5. Effective Date of Coverage: COBRA: first day following loss of Active coverage. Early Retiree: first of the month following retirement. Temporary Employees: the first day of

the month following completion of the Eligibility Waiting Period if working 30 or more hours per week or on January 1 if they met the definition of fulltime under the Affordable Care Act during the most recent measurement period.

6. Location: Not applicable for Early Retirees and COBRA participants.
7. Leave of Absence Status: Not applicable for Early Retirees and COBRA participants. Temporary Employees: An otherwise eligible Temporary Employee on an Employer-approved Leave of Absence shall remain eligible during the first 6 months of leave of absence. Absences extending beyond this period are subject to the COBRA provisions of this Summary Plan Description.
8. Layoff/Rehire: Not applicable.
9. Retirement Status: Non-Medicare eligible retired employees are eligible.

Eligible Family Dependent

Eligible Family Dependent means:

1. The legally recognized Spouse or Domestic Partner of a Subscriber;
2. In relation to a Subscriber, the following individuals:
    a) A biological child, step-child, or legally adopted child;
    b) An unmarried grandchild for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support;
    c) A child placed for adoption with the Subscriber or Spouse;
    d) An unmarried individual for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support; and
    e) A child for whom the Subscriber or Spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law.

Placement for adoption means the assumption and retention by a Subscriber or Spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption). Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.

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;
2. Incapable of self-sustaining employment prior to the limiting age; and
3. Unmarried.

Proof of incapacity must be provided to us 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. Thereafter, Providence Health Plan 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 Providence Health Plan, the individual's coverage will not continue beyond the last date of eligibility.

See section 8.2.4 for information on when and how to add a newborn to the Plan.

Emergency Medical Condition
See section 4.5.1.

Emergency Medical Screening Exams
See section 4.5.1.

Emergency Services
See section 4.5.1.

Employer
Employer means Clackamas County, an Oregon employer, and the Plan Sponsor.

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

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

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental Health and substance use disorder (Substance Abuse) services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including dental and vision care.

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

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

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

- Proven to be safe and efficacious; and
- Pose a significant risk to the health and safety of the Member.

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

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

Fiduciary
Fiduciary means a person entrusted to act on behalf of the Plan consistent with the duties and obligations of plan administration as set forth under applicable law.

Global Fee
See section 4.13.2.

Grievance
See section 7.

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 Employee Retirement Income Security Act (ERISA).

Hearing Aid
See section 4.12.13.

Hearing Assistance Technology
See section 4.12.13.

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 Abuse or Mental Health disorders.

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

In-Network
In-Network means the level of benefits specified in the Benefit Summary and 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, Hospital, Qualified Practitioner, Qualified Treatment Facility, Skilled Nursing Facility, or Pharmacy that has a written agreement with Providence Health Plan to participate as a health care provider for this Plan. For Native American Indian and Alaskan Native Members, Covered Services obtained through Indian Health Services are considered to be Covered Services obtained from an In-Network Provider.

Late Enrollee
Late Enrollee means a person eligible to enroll under a Special Enrollment Period, as described in section 8.3.

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

Non-Medicare Eligible Early Retiree
Non-Medicare Eligible Early Retiree means a Subscriber who retires from employment with Clackamas County and is eligible to enroll in this Plan.

Open Enrollment Period
Open Enrollment Period means a period during each Plan Year, as established by Clackamas County, 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 the Benefit Summary and 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 for this Plan.

Out-of-Pocket Maximum
See section 3.11.2.

Outpatient Surgical Facility

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

Participating Pharmacy

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

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

Plan

Plan means the Clackamas County group health plan, as set forth in this document, the Summary Plan Description, and includes the provisions of any Benefit Summary 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.

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 Qualified Practitioner specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider.

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

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 Providence Health Plan's 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, additional information may be required about the Member's condition and/or the Services requested. Providence Health Plan 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 Plan. Services that require Prior Authorization are shown in section 3.5. 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 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 corrects a congenital deformity or anomaly that results in a functional impairment.

Retail Health Clinic

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

Service

Service means a health care related procedure, surgery, consultation, advice, diagnosis, referral, treatment, supply, medication, prescription drug, device or technology that is provided to a Member by a Qualified Practitioner.

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 or non-Medicare Eligible Early Retiree of Clackamas County who is eligible for benefits and is properly enrolled in accordance with the provisions of this Summary Plan Description.

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

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

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

Usual, Customary and Reasonable (UCR)
When a Service is provided by an In-Network Provider, UCR means charges based on the fee that 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 determined, in Providence Health Plan's reasonable discretion, based on the lesser of:

1. The fee a professional provider usually charges for a given Service;
2. A fee which falls within the range of usual charges for a given Service billed by most professional providers in the same locality or region who have similar training and experience;
3. A fee which is based upon a percentage of the Medicare allowable amount;

4. A fee which is prevalent or which would not be considered excessive in a particular case because of unusual circumstances; or
5. The fee determined by comparing charges for similar Services to a regional or national database adjusted to the geographical area where the Service was performed.

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

Virtual Visit
Virtual Visit means a visit with a Provider using secure internet technology:

- Phone and Video Visit:
  Phone and Video Visit means a Medically Necessary and appropriate consultation through phone and video with an In-Network or Out-of-Network Provider using Providence Health Plan approved secure technology. A Phone and Video Visit must relate to the treatment of a covered illness or injury (see also section 4.3.2).
- Web-direct Visit:
  Web-direct Visit means a Medically Necessary consultation with an In-Network Provider utilizing an online questionnaire to collect information and diagnose common conditions such as cold, flu, sore throat, allergy, ear ache, sinus pain, or UTI (see also section 4.3.2).

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

16. NON-DISCRIMINATION STATEMENT

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

Providence Health Plan and Providence Health Assurance:

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

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

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

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

Language Access Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 Clackamas County self-funded Employee Health Benefit Plan, Clackamas County Early Retiree-COBRA-Temporary Employees Open Option 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 Clackamas County'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, 2021.

By: _____

Printed Name: _____

Title: _____

Company: _____

Date: _____

Administered by

PROVIDENCE
Health Plan

1

Our Mission

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

Our Values

Compassion | Dignity | Justice | Excellence | Integrity

Questions? We're here to help.

Speak to one of our Customer Service representatives at 503-574-7500 or 800-878-4445 (TTY: 771); 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.

©2020 Providence Health Plan. All rights reserved.

2021 Summary Plan Description

General County Employees

Open Option

TABLE OF CONTENTS

1. INTRODUCTION 1

1.1 KEY FEATURES OF YOUR CLACKAMAS COUNTY GENERAL COUNTY EMPLOYEES OPEN OPTION PLAN 2

2. WELCOME TO PROVIDENCE HEALTH PLAN 4

2.1 CLACKAMAS COUNTY GENERAL COUNTY EMPLOYEES OPEN OPTION PLAN 4
2.2 SUMMARY PLAN DESCRIPTION 4
2.3 CUSTOMER SERVICE 5
2.4 REGISTERING FOR A MYPROVIDENCE ACCOUNT 5
2.5 YOUR MEMBER ID CARD 5
2.6 PROVIDENCE NURSE ADVICE LINE 6
2.7 WELLNESS BENEFITS 6
2.8 PRIVACY OF MEMBER INFORMATION 8

3. HOW TO USE YOUR PLAN 10

3.1 IN-NETWORK PROVIDERS 10
3.1.1 Nationwide Network of In-Network Providers 10
3.1.2 Choosing an In-Network Provider 10
3.1.3 Indian Health Services Providers 11
3.2 THE ROLE OF A PRIMARY CARE PROVIDER 11
3.2.1 Primary Care Providers 11
3.2.2 Established Patients with Primary Care Providers 11
3.2.3 Selecting a New Primary Care Provider 12
3.2.4 Changing Your Primary Care Provider 12
3.2.5 Office Visits 12
3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS 13
3.4 NOTICE OF PROVIDER TERMINATION 15
3.5 PRIOR AUTHORIZATION 15
3.6 TRAVEL EXPENSE REIMBURSEMENT 17
3.7 MEDICAL COST MANAGEMENT 17
3.7.1 Coverage of New Technology and New Application of Existing Technology 18
3.8 MEDICALLY NECESSARY SERVICES 18
3.9 APPROVED CLINICAL TRIALS 19
3.10 HOW BENEFITS ARE APPLIED 19
3.11 DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS 19
3.11.1 Understanding Deductibles 20
3.11.2 Understanding Out-of-Pocket Maximums 20

4. COVERED SERVICES 22

4.1 PREVENTIVE SERVICES 22
4.1.1 Physical Examinations and Well-Baby Care 22
4.1.2 Immunizations and Vaccinations 23
4.1.3 Prostate Cancer Screening Exams 23
4.1.4 Colorectal Cancer Screening Exams 23
4.1.5 Preventive Services for Members with Diabetes 24

4.1.6 Diabetes Self-Management Education Program 24
4.1.7 Nutritional Counseling 24
4.1.8 Tobacco Use Cessation Services 24
4.2 WOMEN'S PREVENTIVE HEALTH CARE SERVICES 25
4.2.1 Gynecological Examinations 25
4.2.2 Mammograms 25
4.2.3 Breastfeeding Counseling and Support 25
4.2.4 Family Planning Services 25
4.3 PROVIDER SERVICES 26
4.3.1 Office Visits, Inpatient and Outpatient Hospital Visits, and Home Visits 26
4.3.2 Virtual Visits 26
4.3.3 E-mail Visits 27
4.3.4 Telemedical Services 27
4.3.5 Allergy Shots, Allergy Serums, Injectable and Infused Medications 28
4.3.6 Administration of Anesthesia and Surgical Procedures 28
4.3.7 Immediate Care 28
4.3.8 Retail Health Clinics 29
4.4 DIAGNOSTIC SERVICES 29
4.4.1 Diagnostic Pathology, Radiology Tests, High Tech Imaging and Diagnostic Procedures 29
4.4.2 Sleep Study Services 29
4.5 EMERGENCY CARE AND URGENT CARE SERVICES 29
4.5.1 Emergency Care 29
4.5.2 Emergency Medical Transportation 31
4.5.3 Emergency Eye Care Services 31
4.5.4 Emergency Detoxification Services 31
4.5.5 Urgent Care 32
4.6 INPATIENT HOSPITAL AND SKILLED NURSING FACILITY SERVICES 32
4.6.1 Inpatient Hospital Services 33
4.6.2 Skilled Nursing Facility 33
4.6.3 Inpatient Rehabilitative Care 34
4.6.4 Inpatient Habilitative Care 34
4.6.5 Observation Care 34
4.7 OUTPATIENT SERVICES 34
4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy 34
4.7.2 Outpatient Rehabilitative Services 35
4.7.3 Outpatient Habilitative Services 35
4.8 MATERNITY SERVICES 35
4.9 MEDICAL SUPPLIES, MEDICAL APPLIANCES, PROSTHETIC AND ORTHOTIC DEVICES, AND DURABLE MEDICAL EQUIPMENT (DME) 37
4.9.1 Medical Supplies (including Diabetes Supplies) 37
4.9.2 Medical Appliances 38
4.9.3 Prosthetic and Orthotic Devices 38
4.9.4 Durable Medical Equipment (DME) 38

4.10 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES 39
4.10.1 Mental Health Services 39
4.10.2 Applied Behavior Analysis 39
4.10.3 Substance Abuse Services 40
4.11 HOME HEALTH CARE AND HOSPICE CARE 40
4.11.1 Home Health Care 40
4.11.2 Hospice Care 41
4.12 OTHER COVERED SERVICES 41
4.12.1 Genetic Testing and Counseling Services 41
4.12.2 Inborn Errors of Metabolism 42
4.12.3 Podiatry/Foot Services 42
4.12.4 Reconstructive Surgery 42
4.12.5 Reconstructive Breast Surgery 42
4.12.6 Restoration of Head/Facial Structures; Limited Dental Services 43
4.12.7 Temporomandibular Joint (TMJ) Services 44
4.12.8 Self-Administered Chemotherapy 44
4.12.9 Chiropractic Manipulation 44
4.12.10 Acupuncture 44
4.12.11 Massage Therapy 44
4.12.12 Gender Dysphoria 45
4.12.13 Elective Sterilization 45
4.12.14 Hearing Loss Services 45
4.12.15 Wigs 46
4.12.16 Biofeedback 46
4.13 HUMAN ORGAN/TISSUE TRANSPLANTS 46
4.13.1 Covered Services 47
4.13.2 Benefits for Transplant Facility Services Provided to the Organ Recipient 47
4.13.3 Benefits for Outpatient Medications 48
4.13.4 Benefits for Physician/Provider Services Provided to the Organ Recipient 48
4.13.5 Transplant Prior Authorization 48
4.13.6 Transplant Exclusions 48
4.14 PRESCRIPTION DRUG BENEFIT 49
4.14.1 Using Your Prescription Drug Benefit 49
4.14.2 Use of Out-of-Network Pharmacies 51
4.14.3 Prescription Drug Formulary 51
4.14.4 Prescription Drugs 52
4.14.5 Prescription Drug Quantity 52
4.14.6 Participating Mail-Order and Preferred Retail Pharmacies 52
4.14.7 Prescription Drug Limitations 53
4.14.8 Prescription Drug Exclusions 54
4.14.9 Prescription Drug Disclaimer 55
5. EXCLUSIONS 56
6. CLAIMS ADMINISTRATION 62
6.1 CLAIMS PAYMENT 62
6.1.1 Timely Submission of Claims 63

6.1.2 Right of Recovery 63
6.2 COORDINATION OF BENEFITS 64
6.2.1 Definitions Relating to Coordination of Benefits 64
6.2.2 Order of Benefit Determination Rules 66
6.2.3 Effect on the Benefits of This Plan 68
6.2.4 Right to Receive and Release Needed Information 68
6.2.5 Facility of Payment 68
6.2.6 Right of Recovery 68
6.2.7 Coordination with Medicare 69
6.3 THIRD-PARTY LIABILITY/SUBROGATION 69
6.3.1 Third-Party Liability/Subrogation and How It Affects You 69
6.3.2 Proceeds of Settlement or Recovery 70
6.3.3 Suspension of Benefits and Reimbursement 71
6.3.4 Special Rules for Motor Vehicle Accident Cases 72
7. PROBLEM RESOLUTION 73
7.1 INFORMAL PROBLEM RESOLUTION 73
7.2 MEMBER GRIEVANCE AND APPEAL 73
7.2.1 Your Grievance and Appeal Rights 74
7.2.2 Internal Grievance or Appeal 75
7.2.3 External Review 75
7.2.4 How to Submit Grievances or Appeals and Request Appeal Documents 76
8. ELIGIBILITY AND ENROLLMENT 77
8.1 EMPLOYEE ELIGIBILITY AND ENROLLMENT 77
8.1.1 Employee Eligibility Date 77
8.1.2 Employee Effective Date 77
8.1.3 Employee Enrollment 77
8.2 DEPENDENT ELIGIBILITY AND ENROLLMENT 77
8.2.1 Eligibility Date 77
8.2.2 Additional Requirements for Eligible Family Dependent Coverage 77
8.2.3 Eligible Family Dependent Enrollment 78
8.2.4 Newborn Eligibility and Enrollment 78
8.2.5 Open Enrollment Period 78
8.2.6 Changes in Eligibility 78
8.2.7 Members No Longer Eligible for Coverage 78
8.3 SPECIAL ENROLLMENT PERIODS 79
8.3.1 Loss of Other Coverage 79
8.3.2 New Dependents 80
8.3.3 Court Orders 80
8.3.4 Premium Assistance 80
8.4 LEAVE OF ABSENCE AND LAYOFFS 81
9. TERMINATION OF MEMBER COVERAGE 82
9.1 TERMINATION DATES 82
9.2 TERMINATION AND RESCISSION OF COVERAGE DUE TO FRAUD OR ABUSE 82
9.3 NON-LIABILITY AFTER TERMINATION 82

9.4 DISENROLLMENT FROM THIS PLAN 83
9.5 NOTICE OF CREDITABLE COVERAGE 83
9.6 CLACKAMAS COUNTY'S RIGHT TO TERMINATE OR AMEND PLAN 83
10. CONTINUATION OF GROUP MEDICAL BENEFITS 84
10.1 COBRA CONTINUATION COVERAGE 84
10.1.1 Subscriber's Continuation Coverage 84
10.1.2 Spouse's or Domestic Partner's Continuation Coverage 84
10.1.3 Dependent's Continuation Coverage 84
10.1.4 Notice Requirements 85
10.1.5 Type of COBRA Continuation Coverage 85
10.1.6 COBRA Election Rights 85
10.1.7 COBRA Premiums 85
10.1.8 Length of COBRA Continuation Coverage 85
10.1.9 Extension of Continuation Period 86
10.1.10 Trade Act of 2002 87
10.1.11 When COBRA Continuation Coverage Ends 87
11. MEMBER RIGHTS AND RESPONSIBILITIES 88
11.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES 88
11.2 INFORMATION FOR NON-ERISA MEMBERS (PARTICIPANTS) 89
12. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO) 91
12.1 DEFINITIONS 91
12.2 NOTICE UPON RECEIPT OF ORDER 91
12.3 NOTICE OF DETERMINATION 91
12.4 ENROLLMENT OF ALTERNATE RECIPIENT 92
12.5 COST OF COVERAGE 92
12.6 REIMBURSEMENT OF PLAN EXPENSES 92
12.7 STATUS OF ALTERNATE RECIPIENT 93
12.8 TREATMENT OF NATIONAL MEDICAL SUPPORT NOTICE 93
13. GENERAL PROVISIONS 94
13.1 CONFLICTS OF PROVISIONS 94
13.2 CONTROLLING STATE LAW 94
13.3 DUPLICATING PROVISIONS 94
13.4 FAILURE TO PROVIDE INFORMATION OR PROVIDING INCORRECT OR INCOMPLETE INFORMATION 94
13.5 GENDER AND NUMBER 94
13.6 HEADINGS 94
13.7 LEGAL ACTION 95
13.8 LIMITATIONS AND PROVISIONS 95
13.9 MEMBER RESPONSIBILITY 95
13.10 MEMBERSHIP ID CARD 95
13.11 NON-TRANSFERABILITY OF BENEFITS 95
13.12 NO GUARANTEE OF EMPLOYMENT 95
13.13 NO RECOURSE FOR ACTS OF PROVIDERS 96
13.14 NON-WAIVER 96

13.15 NOTICE 96
13.16 NOTICE REQUIRED FOR REIMBURSEMENT AND PAYMENT OF CLAIM 96
13.17 PAYMENT OF BENEFITS TO PERSONS UNDER LEGAL DISABILITY 96
13.18 PHYSICAL EXAMINATION AND AUTOPSY 97
13.19 PROFESSIONAL REVIEW AND RIGHT TO EXAMINE RECORDS 97
13.20 REQUIRED INFORMATION TO BE FURNISHED 97
13.21 RIGHT OF RECOVERY 97
13.22 SEVERABILITY 97
13.23 STATE MEDICAID BENEFITS RIGHTS 98
13.24 SUGGESTIONS 98
13.25 VETERANS' RIGHTS 98
13.26 WORKERS' COMPENSATION INSURANCE 98
14. PLAN ADMINISTRATION 99
14.1 TYPE OF ADMINISTRATION 99
14.2 PLAN INFORMATION 99
14.3 PLAN DATES 99
14.4 PLAN SPONSOR INFORMATION 99
14.5 ADMINISTRATIVE SERVICES PROVIDED BY 99
14.6 AGENT FOR SERVICE OF LEGAL PROCESS 99
14.7 ADMINISTRATIVE SERVICES 100
14.7.1 COMPLETE ALLOCATION OF FIDUCIARY RESPONSIBILITIES 100
14.8 ENGAGEMENT OF ADVISORS 100
14.9 INDEMNIFICATION 100
14.10 AMENDMENT OR TERMINATION OF PLAN 100
14.10.1 Right to Amend or Terminate 100
14.10.2 Manner of Action 101
14.10.3 Effect on Benefits 101
14.11 PROTECTED HEALTH INFORMATION 101
14.11.1 Disclosure 101
14.11.2 Security 102
15. DEFINITIONS 103
16. NON-DISCRIMINATION STATEMENT 116

1. INTRODUCTION

Statement from Plan Sponsor

Clackamas County has designed this Plan in cooperation with Providence Health Plan. The benefits under the Plan are provided by Clackamas County on a self-insured basis. Clackamas County 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.

Clackamas County Benefits & Wellness: 503-655-8550

Customer Service Quick Reference Guide:

Medical 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 Chemical Dependency 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)
Providence Resource Line To find a care provider or to register for Providence classes	503-574-6595
myProvidence Help Desk	503-216-6463 877-569-7768 (toll-free)
LifeBalance	503-234-1375 888-754-LIFE (toll-free) www.LifeBalanceProgram.com
Provider Directory	ProvidenceHealthPlan.com/findaprovider

1.1 KEY FEATURES OF YOUR CLACKAMAS COUNTY GENERAL COUNTY EMPLOYEES OPEN OPTION PLAN

- Some capitalized terms have special meanings. Please see section 15, Definitions.
- In this Summary Plan Description, Providence Health Plan and Clackamas County 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;
  - Providence Health Plan's 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 3 and your Plan Benefit Summary for additional information.
- Some Services are covered only under your In-Network benefits:
  - Web-direct Visits, as specified in section 4.3.2;
  - E-mail Visit Services, as specified in section 4.3.3;
  - Temporomandibular Joint (TMJ) Services, as specified in section 4.12.7;
  - Tobacco Use Cessation Services, as specified in section 4.1.8;
  - Water births, as specified in section 4.8;
  - Human Organ/Tissue Transplant Services, as specified in section 4.13; and
  - Any item listed in your Benefit Summary as "Not Covered" Out-of-Network.
- Coverage is provided in full for most preventive Services when those Services are received from specified In-Network Providers. See your Benefit Summary for additional information.
- 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 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 3.5.**
- Coverage limitations and exclusions apply to certain Services, as stated in sections 3, 4, and 5 and the Benefit Summary.
- 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 Plan documents. 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 or amendments that accompany these documents, the agreement between Providence Health Plan and the Plan Sponsor (if any), 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) Providence Health Plan/ Plan Sponsor agreement, (3) Summary Plan Description, (4) Benefit Summary(ies), and (5) 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 Clackamas County General County Employees and their Dependents.

2.1 CLACKAMAS COUNTY GENERAL COUNTY EMPLOYEES OPEN OPTION PLAN

Your 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 us to Prior Authorize treatment. If you receive Covered Services from Out-of-In-Network Providers, it is your responsibility to make sure the Services listed in section 3.5 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 participating with Providence Health Plan, 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 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 for what you owe later. 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 Clackamas County. 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 15. 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:

- **Clackamas County General County Open Option Medical Benefit Summary** and any other Benefit Summary documents issued with this Plan. These documents are available at www.ProvidenceHealthPlan.com when you register for a myProvidence account as explained in section 2.4. Benefit Summaries detail your Deductible, 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 or check with your Employer's human resource department 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.
- 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. 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. If you have questions or need assistance registering for or accessing an existing account, contact myProvidence customer service at 877.569.7768.

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 confer 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:

- Visit your health care provider or facility.
- Register online for your myProvidence account.
- Call for Mental Health/Substance Abuse 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 recorded message, a registered nurse will come on line to assist you.

Please have your Member ID Card available when you call.

2.7 WELLNESS BENEFITS

Providence Resource Line — 503-574-6595; 800-562-8964

Providence Resource Line is your connection to information and services on classes, self-help materials, tobacco-use cessation services, and for referrals to Providence Health Plan In-Network Providers and to Providence Health & Services programs and services. Services and health-education vary by geographic service area.

Health Education

Providence Health Plan offers a wide variety of classes to help you achieve healthy lifestyle and wellness goals. We can assist you in learning to eat right and manage your weight, prepare for childbirth and much more. If you have diabetes, health education classes also are available (see section 4.1.6, for further information).

Providence Health Plan Members receive discounts on health education classes. Your costs, services and the health education classes available may vary by geographic-service area. For more information on classes available in your area, call the Providence Resource Line at 503-574-6595 or 800-562-8964 or visit www.providence.org/classes.

Health Coaching
Providence Health Plan offers Members free coaching support for weight loss, diabetes prevention, nutrition, stress management, exercise, sleep and tobacco cessation. For more information on health coaching, call 503-574-6000 (TTY: 711) or 888-819-8999 or visit www.ProvidenceHealthPlan.com/healthcoach.

Care Management
Providence Care Management provides Members with information and assistance with healthcare navigation, as well as managing chronic conditions from a Registered Nurse Care Manager.

You can access these Services by calling 800-662-1121 or e-mailing caremanagement@providence.org.

Tobacco Use Cessation
Your Wellness Benefits include access to tobacco-use cessation programs provided through our Providence Health & Services Hospitals as well as through Quit for Life. These programs address tobacco dependence through a clinically proven, comprehensive approach to tobacco-use cessation that treats all three aspects of tobacco use – physical addiction, psychological dependence, and behavioral patterns. (See section 4.1.8 regarding coverage for Tobacco Use Cessation Services).

More information about our Tobacco-Use Cessation programs can be found online at http://www.providence.org/healthplans/members/healthbalance/smokingcessation.aspx, or by calling 503-574-6595 or 800-562-8964.

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

Wellness information on our website — www.ProvidenceHealthPlan.com
Visit Providence Health Plan online at www.ProvidenceHealthPlan.com for medical information, class information, information on extra values and discounts, and a wide array of other information described with your good health in mind. You also may set up your own myProvidence account to gain access to your specific personal health plan information. See *Registering for a myProvidence account*, section 2.4, for more details.

LifeBalance — 503-234-1375 or 888-754-LIFE www.LifeBalanceProgram.com
This program offers exclusive discounts to Providence Health Plan Members on a wide variety of health and wellness programs, as well as recreational, cultural and wellness activities. You can save on professional instruction, fitness club memberships, yoga classes, and much more. You also have access to discounted events, such as white-water rafting, ski trips, theater nights, and sporting events.

Learn more by visiting the LifeBalance website at www.LifeBalanceProgram.com or calling LifeBalance at 503-234-1375 or 888-754-LIFE. Please have your Providence Health Plan Member ID Card ready when you request LifeBalance discounts.

Assist America

Your wellness benefits include access to travel assistance services and identity theft protection services.

Travel Assistance Services include emergency logistical support to members traveling internationally or people traveling 100 miles from home. Learn more by visiting www.assistamerica.com or calling Assist America at 609-986-1234 or 800-872-1414.

Assist America also provides identity theft protection services 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. Please have your Providence Health Plan Member ID card ready, 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 https://healthplans.providence.org/members/rights-notices or by calling Customer Service.

Appointment of Authorized Representative

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

Confidentiality and your Employer

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

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

1. In compliance with the applicable provisions of HIPAA; and
2. Due to a HIPAA compliant authorization, the Member has completed to allow the Employer access to the Member's PHI; or
3. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer. The details of this required certification can be reviewed at https://healthplans.providence.org/about-us/privacy-notices-policies/protected-health-information-and-your-employer/.

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. HOW TO USE YOUR PLAN

Our goal is maintaining your health by promoting wellness and preventive care. We encourage you to work closely with one provider, your 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 section 4 of this Summary Plan Description.

3.1 IN-NETWORK PROVIDERS

Providence Health Plan has contractual arrangements with certain physicians/providers, hospitals and facilities. Our agreements with these "In-Network Providers" enable you to receive quality health care for a reasonable 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.

3.1.1 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 of Oregon and southwest Washington.

3.1.2 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 the Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider. If you do not have access to our website, please call Customer Service to request In-Network Provider Information.

Advantages of 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 3.5.
- 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 an In-Network Primary Care Provider, whenever possible.

3.1.3 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 St., Ste. 800
Portland, OR 97209
Telephone: 503-414-5555

3.2 THE ROLE OF A PRIMARY CARE PROVIDER

To encourage optimum health, we promote wellness and preventive care. We also believe wellness and overall health is enhanced by working closely with one physician or provider – your 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 an In-Network Primary Care Provider as soon as possible.

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

3.2.2 Established Patients with Primary Care Providers

If you and your family already see a provider, you may want to check the provider directory to see if your provider is an In-Network Primary Care Provider for Providence Health Plan. If your provider is participating with us, let their office know you are now a Providence Health Plan Member.

3.2.3 Selecting a New Primary Care Provider

We recommend 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 they are 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.

3.2.4 Changing Your Primary Care Provider

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.

3.2.5 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 the Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider, or call Customer Service to choose a specialist who 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. (For certain Plans, there is a Member Copayment for specialist visits instead of a Coinsurance. If you are on one of these Plans, you will need to pay your Member Copayment at the time of your visit. Please check your Benefit Summary for your specific coverage information.)

Alternative Care Providers

This Plan includes coverage for office visits to alternative care providers as listed in your Benefit Summary. See section 15 for the definition of Alternative Care Provider. For coverage of chiropractic manipulation and acupuncture, see sections 4.12.9, 4.12.10 and your Benefit Summary.

3.3 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 3.5 for 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.

IMPORTANT NOTE: Your Plan only pays for Covered Services received from Out-of-Network Providers at Usual, Customary, and Reasonable rates (UCR) (see Section 15, 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 Summary Plan Description. Your Plan will only pay for Medically Necessary Covered Services. No matter what type of provider you see, the treatments, supplies, and medications excluded by this Plan are not covered.

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

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

- Web-direct Visits (see section 4.3.2).
- E-mail Visits (see section 4.3.3).
- Temporomandibular Joint (TMJ) Services (see section 4.12.7).
- Tobacco Use Cessation Services (see section 4.1.8).
- Retail Health Clinic Visits (see section 4.3.8).
- Human Organ/Tissue Transplants (see section 4.13).
- Any item listed in your Benefit Summary as "Not Covered" under Out-of-Network.

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

After you meet your Deductible, if applicable, and if the Services provided are Medically Necessary Covered Services, we will provide payment to Out-of-Network Providers according to Usual, Customary and Reasonable (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 15 for the definition of UCR.

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

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

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

Payment for 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.

3.4 NOTICE OF PROVIDER TERMINATION

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

3.5 PRIOR AUTHORIZATION

While Prior Authorization is a requirement for coverage of certain Services under this Plan, Prior Authorization is not a treatment directive. The actual course of medical treatment that a Member chooses remains strictly a matter between the Member and the 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 Medical Necessity.

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. You or your Out-of-Network provider must contact us to obtain Prior Authorization. See section 3.3 for additional information about Out-of-Network Providers.

Services requiring Prior Authorization:

- All inpatient admissions to a Hospital (not including emergency room care), Skilled Nursing Facility or a rehabilitation facility, all emergency hospitalizations (we need to be notified within 48 hours, or as soon as reasonably possible), and all Hospital and birthing center admissions for maternity/delivery Services.
- All outpatient surgical procedures.
- Anesthesia Care with Diagnostic Endoscopy.
- All Travel Expense Reimbursement, as provided in section 3.6.
- All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services for Mental Health and Substance Abuse, as provided in sections 4.10.1 and 4.10.3.
- All Applied Behavior Analysis, as provided in section 4.10.2.
- All Human Organ/Tissue Transplant Services, as provided in section 4.13.
- All Restoration of Head/Facial Structures; Limited Dental Services, as provided in section 4.12.6.
- All Temporomandibular Joint (TMJ) Services, as provided in section 4.12.7.
- All High Tech Imaging, including PET, CT, CTA, MRI and MRA, Nuclear Cardiac Study Services, and echocardiography Services, as provided in section 4.4.1;
- All Sleep Study Services, as provided in section 4.4.2.
- Certain Home Health Care Services, as provided in section 4. 11.1.
- Certain Hospice Care Services, as provided in section 4.11.2.
- Certain Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment, as provided in section 4.9.

- Certain outpatient services including, but not limited to, neurodevelopmental therapy, neurological testing, and botulinum therapies.
- All outpatient hospitalization and anesthesia for dental Services, as provided in section 4.12.6.
- All Genetic Testing Services, as provided in section 4.12.1.
- Certain medications, including certain immunizations, received in your Provider's office, as provided in sections 4.3.5 and 4.1.2.
- Certain prescription drugs specified in our Formulary, as provided in section 4.14.1.
- Certain infused Prescription Drugs administered in a hospital-based infusion center, as provided in section 4.7.1.

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 section 3.3, a 50% **penalty,** not to exceed $2,500 for each Covered Service, will be applied to the claim.

Should Providence Health Plan 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.

3.6 TRAVEL EXPENSE REIMBURSEMENT

Subject to Prior Authorization, if you are unable to locate an In-Network Provider to provide Medically Necessary Covered Services for your specific condition within 50 miles of your home, the Plan will reimburse your travel expense to the nearest In-Network Provider within 300 miles of your home. Reimbursement will be based on the federal medical mileage reimbursement rate in effect on the date of service. Travel expense reimbursement is limited to $1,500 per calendar year. If an overnight stay is required, food and lodging are reimbursable up to $150 per diem (per day). Per diem expenses apply to the $1,500 travel expenses reimbursement maximum. (Note: Transplant Covered Services include a separate travel expense benefit; see section 4.13.1).

3.7 MEDICAL COST MANAGEMENT

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

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 Services 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.

3.7.1 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 7.

3.8 MEDICALLY NECESSARY SERVICES

We believe our Members are entitled to comprehensive medical care within the standards of good medical practice. Providence Health Plan's medical directors and special committees

of In-Network Providers determine which Services are Medically Necessary, as defined in section 15. 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 our guidelines. Obtaining confirmation of coverage from Providence Health Plan beforehand is always recommended.

3.9 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, the Plan 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.

3.10 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.

3.11 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.

3.11.1 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 us. Deductible amounts are payable to your Qualified Practitioner after we have processed your claim.

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

Common In-Network and Out-of-Network Deductible: Your Plan has a **Common Deductible**, as listed in your Benefit Summary. **A Common Deductible applies to both In-Network and Out-of-Network benefits**. The Common 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 the 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 amount shown in the Benefit Summary that applies when two 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.

3.11.2 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.

Common In-Network and Out-of-Network Out-of-Pocket Maximums: Your Plan has a Common In-Network and Out-of-Network Out-of-Pocket Maximum, as listed in your Benefit Summary. The Common Out-of-Pocket Maximum can be met by 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 two or more must pay in a Calendar Year, as shown in the Benefit Summary, before the Plan begins to pay 100% for Covered Services for enrolled Family Members. When the combined Copayment, Coinsurance and Deductible expenses of enrolled Family Members meet the family Out-of-Pocket Maximum, all remaining individual Out-of-Pocket Maximums will be waived for the family for that Calendar Year.

Note: Once any 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 by this Plan;
- Services not covered because Prior Authorization was not obtained, as required in section 3.5;
- 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; and
- Any penalties you must pay if you do not follow 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. COVERED SERVICES

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

Please refer to your Benefit Summary for details of your specific coverage. You can view your Member materials by registering for a myProvidence account on our website at www.ProvidenceHealthPlan.com (see section 2.4). If Clackamas County modifies your benefits, you will be notified in writing of the changes.

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

4.1 PREVENTIVE SERVICES

Preventive Services are covered as shown in the Benefit Summary. For Women's Preventive Health Care Services, see section 4. 2.
In accordance with the Patient Protection and Affordable Care Act of 2010 and related legislation, your Plan covers the following Services in full when received from In-Network Providers:

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

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

4.1.1 Physical Examinations and Well-Baby Care

Periodic health exams and well-baby care Services are covered in full only when received In-Network. These services are covered as stated in your Benefit Summary. Your provider will determine which tests are necessary for your physical exam according to your medical history and your current health status. More frequent exams will be covered if your provider determines that they are necessary. Vision and hearing screening services are covered when performed during a periodic health examination or well-baby care examination, and as indicated in section 4.1.9. In order for a child to be eligible for benefits for routine newborn baby care, the child must be properly enrolled as outlined in section 8. Ancillary Services, such as immunizations, are covered at the specified benefit level when billed by the provider.

Recommended Guidelines:

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. The Plan will not cover this additional fee.

Covered Services do **NOT** include the following:

1. Services for laser surgery, radial keratotomy and any other surgery to correct myopia, hyperopia or stigmatic error, vision therapy, orthoptic treatment (eye exercises);
2. Services for routine eye and vision care, refractive disorders, eyeglass frames and lenses, contact lenses; and
3. Hearing aids, including all Services related to the examination and fitting of hearing aids; except as specified in section 4.12.14.

4.1.2 Immunizations and Vaccinations

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

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

4.1.3 Prostate Cancer Screening Exams

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

4.1.4 Colorectal Cancer Screening Exams

Benefits for colorectal cancer screening examinations 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.

- 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.

4.1.5 Preventive Services for Members with Diabetes

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

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

4.1.6 Diabetes Self-Management Education Program

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

4.1.7 Nutritional Counseling

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

4.1.8 Tobacco Use Cessation Services

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

4.2 WOMEN'S PREVENTIVE HEALTH CARE SERVICES

Women may choose to receive Women's Preventive Health Care Services from a Primary Care Provider or a Women's Health Care Provider. 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.

4.2.1 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 4.2.4). Benefits also include follow-up exams for any medical conditions discovered during an Annual gynecological exam that require additional treatment.

4.2.2 Mammograms

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

4.2.3 Breastfeeding Counseling and Support

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

4.2.4 Family Planning Services

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

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

- Intrauterine device (IUD) insertion and removal;
- Medical exams and consultation for family planning;
- Depo-Provera to prevent pregnancy;
- Diaphragm devices;
- Removal of implantable contraceptives; and
- Oral contraceptives (birth control pills) listed in our Formulary. FDA-approved women's prescription contraceptives: up to 3 months initial dispensing, then up to 12 months subsequent dispensing at any Network Pharmacy.

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 your medical supply benefit.

For coverage of tubal ligation, see Elective Sterilization, section 4.12.13.

4.3 PROVIDER SERVICES

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

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

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

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

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

4.3.2 Virtual Visits

The Plan provides coverage for Virtual Visits using secure internet technology:

- Phone and Video Visits: Phone and Video Visits are covered as shown in your Benefit Summary. All Phone and Video Visits must be Medically Necessary and may be received from authorized In-Network or Out-of-Network Providers. Not all Providers are contracted with us to provide Phone and Video Visits. Providers who are authorized to provide Phone and Video Visits have agreed to use secure internet technology approved by us to protect your information from unauthorized access or release.
- Web-direct Visits: Web-direct Visits for common conditions such as cold, flu, sore throat, allergy, ear ache, sinus pain, or UTI are covered as shown in your Benefit Summary. The Member completes a questionnaire to describe the common condition. The questionnaire is reviewed by an In-Network Provider who makes a diagnosis and sends a treatment plan back to the Member. If needed, a prescription is sent to the Member's pharmacy. All Web-direct Visits must be Medically Necessary and received from authorized In-Network Providers.

4.3.3 E-mail Visits

E-mail Visits are covered in full and must be received from In-Network Providers. Not all In-Network Providers offer E-mail Visits. Medical doctors (M.D.), doctors of osteopathy (D.O.), nurse practitioners (N.P.) and physician assistants (P.A.) are the only categories of providers 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 the Plan;
- 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 Abuse Covered Services (as provided in section 4.10).

4.3.4 Telemedical Services

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

- Is Medically Necessary;
- Is provided by a Qualified Practitioner;
- Is determined to be safely and effectively provided using synchronous two-way interactive video conferencing according to generally accepted health care practices and standards; and

- The application and technology used to provide the Telemedical Service meet all standards required by state and federal laws governing the privacy and security of protected health information.

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

4.3.5 Allergy Shots, Allergy Serums, Injectable and Infused Medications

Allergy shots, allergy serum, injectable medications, and total parenteral nutrition (TPN) received in your Provider's office are covered as shown in your Benefit Summary. Therapy and testing for treatment of allergies including, but not limited to, Services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment are covered only when such therapy or testing is approved by the American Academy of Allergy and Immunology, or the Department of Health and Human Services or any of its offices or agencies. Some injectable medications may require Prior Authorization, as listed in the Medical benefit drug prior authorization list available on our website at https://healthplans.providence.org/members/pharmacy-resources/Pages/default.aspx or by calling Customer Service. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. See section 4.7.1 for coverage of infusion at Outpatient Facilities.

4.3.6 Administration of Anesthesia and Surgical Procedures

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

4.3.7 Immediate Care

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

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

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

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

4.4 DIAGNOSTIC SERVICES

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

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

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

4.4.2 Sleep Study Services

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

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

4.5 EMERGENCY CARE AND URGENT CARE SERVICES

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

4.5.1 Emergency Care

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

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

Coverage is provided without Prior Authorization for Emergency Medical Screening Exams and stabilization of an Emergency Medical Condition. Hospitalization for an Emergency

Medical Condition requires notification to Providence Health Plan within 48 hours, or as soon as reasonably possible following the onset of treatment, in order for coverage to continue.

Definitions:
"Emergency Medical Condition" is a medical condition that manifests itself by acute symptoms of sufficient severity that a prudent layperson, possessing an average knowledge of health and medicine, would reasonably expect that failure to receive immediate medical 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:

- An Emergency Medical Screening Exam or behavioral health assessment that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
- Such further medical examination and treatment as are required under the Emergency Medical Treatment and Active Labor Act (42 U.S.C. 1395dd) to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at the Hospital.

"*Emergency Medical Screening Exams"* include medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.

Your Plan covers Emergency Services in the emergency room of any Hospital. **Emergency room Services are covered when your medical condition meets the guidelines for emergency care as stated above. Coverage includes Services to stabilize an Emergency Medical Condition and Emergency Medical Screening Exams.**

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

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

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

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

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

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

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

Note: While Emergency Services received from Out-of-Network Providers at Out-of-Network Facilities are covered under your In-Patient benefit until the time that your condition becomes stable, the Out-of-Network Providers and Out-of-Network Facilities are not contracted with Providence Health Plan. Therefore, the claims are priced using Usual, Reasonable and Customary (UCR) pricing, as described in section 3.3. Unless otherwise prohibited by state or federal law, you may be billed by the Out-of-Network Providers and Out-of-Network Facilities for amounts above the Allowed Amount of the claim, as determined by UCR.

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

4.5.2 Emergency Medical Transportation

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

4.5.3 Emergency Eye Care Services

Covered Services include the initial care for Emergency Medical Conditions 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.

4.5.4 Emergency Detoxification Services

Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a Substance Abuse treatment program, as stated in section 4.10.3, 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. Continuing or follow-up care is not a Covered Service unless Prior Authorized by Providence Health Plan.

4.5.5 Urgent Care

Urgent Care is treatment you need right away for an illness or injury that is not life threatening. This includes, but is not limited to, minor sprains, minor cuts and burns, and ear, nose, and throat infections. Routine care that can be delayed until you can be seen by a physician or provider in their 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. They may either suggest that you come to the office or go to an emergency room or Urgent Care center. If you can be treated in your provider's office or at an In-Network Urgent Care center your out-of-pocket expense will usually be lower.

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

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

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

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

If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will 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 6.1.1.

4.6 INPATIENT HOSPITAL AND SKILLED NURSING FACILITY SERVICES

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

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

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

- Non-skilled care for senile deterioration, mental deficiency, or developmental disability.

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

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

4.6.1 Inpatient Hospital Services

Benefits are provided as shown in 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 an In-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; and
- Hospital services and supplies necessary for treatment and furnished by the Hospital, such as use of the operating and recovery rooms, anesthesia, dressings, medications, whole blood and blood products, oxygen, X-ray, and laboratory Services during the period of inpatient hospitalization. (Personal items such as guest meals, slippers, etc., are not covered.)

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

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

4.6.2 Skilled Nursing Facility

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

4.6.3 Inpatient Rehabilitative Care

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

4.6.4 Inpatient Habilitative Care

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

4.6.5 Observation Care

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

4.7 OUTPATIENT SERVICES

4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy

Benefits are provided as shown in the Benefit Summary and include Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider’s office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, and therapeutic procedures as ordered by your Qualified Practitioner. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. The Plan may require that you obtain a second opinion for some 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 3.5.

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

4.7.2 Outpatient Rehabilitative Services

Benefits are included for outpatient physical, occupational and speech therapy Covered Services provided by a physician or licensed/registered therapist, as stated in the Benefit Summary, to restore or improve lost function following illness or injury.

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). All Services are subject to review for Medical Necessity. Limits do not apply to Mental Health Covered Services. (See section 4.6.3 for coverage of Inpatient Rehabilitative Services.)

Covered Services under this benefit do NOT include:

- Chiropractic adjustments and manipulations of any spinal or bodily area;
- Exercise programs;
- Rolfing, polarity therapy and similar therapies; and
- Rehabilitation services provided under an authorized home health care plan as stated in section 4.11.

4.7.3 Outpatient Habilitative Services

Coverage is provided, as shown in the Benefit Summary, for Medically Necessary outpatient habilitative Services. All Services are subject to review for Medical Necessity and must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. Coverage is provided at the same benefit level as Outpatient Rehabilitative Care listed in your Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 4.6.4 for coverage of Inpatient Habilitative Services.)

4.8 MATERNITY SERVICES

Your benefits include coverage for comprehensive maternity care.

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

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

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**.

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

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

PLEASE NOTE: Newborn nursery care, newborn nurse home visits, and any other Services provided to your newborn are covered only when the newborn child is properly enrolled under this Plan within time frames outlined in Newborn Eligibility and Enrollment, section 8.2.4.

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

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

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

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

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

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

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

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

4.9.1 Medical Supplies (including Diabetes Supplies)

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

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

4.9.2 Medical Appliances

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

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

4.9.3 Prosthetic and Orthotic Devices

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

4.9.4 Durable Medical Equipment (DME)

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

4.10 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

This Plan complies with Oregon and Federal Mental Health Parity.

4.10.1 Mental Health Services

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

Covered Services include diagnostic evaluation, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services. All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services must be Prior Authorized as specified in section 3.5.

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

4.10.2 Applied Behavior Analysis

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

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

Exclusions to ABA Services:

- Services provided by a family or household member;
- Services that are custodial in nature, or that constitute marital, family, or training services;
- Services that are educational or correctional that are provided by a school or halfway house or received as part of an 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.

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

4.10.3 Substance Abuse Services

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

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

Prior Authorization is required for all inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services, as specified in section 3.5.

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

In an emergency situation, go directly to a Hospital emergency room. You do not need Prior Authorization for emergency treatment; however, 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.

4.11 HOME HEALTH CARE AND HOSPICE CARE

4.11.1 Home Health Care

Benefits for home health care Covered Services are shown in the Benefit Summary and 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.

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

Home health care will not be reimbursed unless your Qualified Practitioner certifies that the home health care Services will be provided or coordinated by a state-licensed or Medicare-certified Home Health 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;
3. Charges for supervision of Home Health Providers; or
4. Services that consist principally of Custodial Care including, but not limited to, care for senile deterioration, mental deficiency, mental illness, developmental disability or care of a chronic or congenital condition on a long-term basis.

4.11.2 Hospice Care

Benefits are included for hospice care as shown in the Benefit Summary and as stated in this section. In addition, the following criteria must be met:

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

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

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

Respite care is not covered.

4.12 OTHER COVERED SERVICES

4.12.1 Genetic Testing and Counseling Services

Genetic testing and counseling are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in

planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature. Genetic testing requires Prior Authorization as shown in section 3.5.

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

4.12.2 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 4.9.1.

4.12.3 Podiatry/Foot Services

Benefits include Covered Services of a podiatrist or other Qualified Practitioner and are provided as shown in the Physician/Provider Services section of the Benefit Summary. Covered Services include, but are not limited to, the fitting and follow up exam for removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are covered as stated in section 4.9.2 (Medical Appliances). Covered Services do not include routine foot care and the removal of corns or calluses, unless you have diabetes.

4.12.4 Reconstructive Surgery

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

4.12.5 Reconstructive Breast Surgery

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

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

- All stages of reconstruction of the involved breast following a mastectomy;
- Surgery and construction of the other breast to produce a symmetrical appearance;
- Prostheses; and

- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

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

4.12.6 Restoration of Head/Facial Structures; Limited Dental Services

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

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

Exclusions that apply to Covered Services include:

- Cosmetic Services;
- Services rendered to improve a condition that falls within the normal range of such conditions;
- Routine Orthodontia;
- Services to treat tooth decay, periodontal conditions and deficiencies in dental hygiene;
- Removal of impacted teeth;
- The making or repairing of dentures;
- Orthognathic surgery to treat developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth; and
- Services to treat temporomandibular joint syndrome, including orthognathic surgery, except as provided in section 4.12.7.

<u>Outpatient Hospitalization and Anesthesia for Limited Dental Services</u>

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.

4.12.7 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 4.9.2 (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.

4.12.8 Self-Administered Chemotherapy

Self-administered chemotherapy agents, including oral medications and injectable medications, are covered when received from a Participating retail or specialty Pharmacy.

Self-administered chemotherapy is covered under your Outpatient Chemotherapy benefit. Self-administered chemotherapy is covered under your Prescription Drug benefit when that coverage results in a lower out-of-pocket expense to the Member (See section 4.14).

4.12.9 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.

4.12.10 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.

4.12.11 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.

4.12.12 Gender Dysphoria

Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for a list of services requiring Prior Authorization.

4.12.13 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.

4.12.14 Hearing Loss Services

Definitions:

Cochlear Implant

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

Hearing Aid

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

Covered Services:

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

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

Cochlear implants:

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

Hearing aids & related accessories:

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

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.

Hearing Assistance Technology:

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

Limits to Hearing Loss Services

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

4.12.15 Wigs

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

4.12.16 Biofeedback

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

4.13 HUMAN ORGAN/TISSUE TRANSPLANTS

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

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

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

4.13.1 Covered Services

Covered Services for transplants are limited to Services that:

1. Are determined by Providence Health Plan to be Medically Necessary and medically appropriate according to national standards of care;
2. Are provided at a facility approved by us or under contract with 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 lifetime benefit maximum for transportation, food and lodging. Food and lodging is subject to a $150 per diem. Per diem expenses apply to the $5,000 travel expenses lifetime 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.

4.13.2 Benefits for Transplant Facility Services Provided to the Organ Recipient

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

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

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

4.13.3 Benefits for Outpatient Medications

Outpatient prescription medications for transplant-related Services, including anti-rejection (immunosuppressive) drugs, are not eligible for reimbursement under the medical benefits of this Plan. Benefits for outpatient prescription drugs are provided under this Plan's Prescription Drug Benefit and those benefits are subject to the terms and limitations of that Benefit.

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

Benefits for physician/provider Services are provided as shown in the Benefit Summary. The Member/recipient is responsible for the 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.

4.13.5 Transplant Prior Authorization

(See also section 3.5.)

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.

4.13.6 Transplant Exclusions

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

- Any transplant procedure performed at a transplant facility that has not been approved by us;
- Any transplant that is Experimental/Investigational, as determined by Providence Health Plan;

- Services or supplies for any transplant that are not specified as Covered Services in section 4.13, such as transplantation of animal organs or artificial organs;
- Services related to organ/tissue donation by a Member if the recipient is not a Member or the Member/recipient is not eligible for transplant benefits under this Plan; and
- Transplant-related travel expenses for the donor and the donor's and recipient's family members.

4.14 PRESCRIPTION DRUG BENEFIT

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

Prescription Drug Definition

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 legend drug in a therapeutic amount; and
4. Any medicinal substance which has been approved by the Oregon Health Evidence Review Commission as effective for the treatment of a particular indication.

4.14.1 Using Your Prescription Drug Benefit

Your Prescription Drug Benefit requires that you fill your prescriptions at a Participating Pharmacy.

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

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

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

- Please present your Member ID Card to the Participating Pharmacy at the time you request Services. If you have misplaced or do not have your Member ID Card with you, please ask your pharmacist to call us.
- All covered Services are subject to the Copayments or Coinsurance listed in your Benefit Summary.
- If you choose a brand-name drug when a generic-equivalent is available, any difference in cost for Prescription Drug Covered Services will not apply to your Calendar Year Deductibles and Out-of-Pocket Maximums.

- The amount paid by a manufacturer discount and/or copay assistance programs for a brand-name drug when a generic equivalent is available may not apply towards 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 Benefit or need assistance processing your prescription.
- Copayments or Coinsurance are due at the time of purchase. If the cost of your Prescription Drug is less than your Copayment, you will only be charged the cost of the Prescription Drug.
- You may be assessed multiple Copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- You may purchase up to a 90-day supply of each maintenance drug at one time using a Participating mail service or preferred retail Pharmacy. Not all drugs are covered for more than a 30-day supply, including compounded medications, drugs obtained from specialty pharmacies, and limited distribution pharmaceuticals. To obtain prescriptions by mail, your physician or provider can call in 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 www.ProvidenceHealthPlan.com. (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 your Medical Supplies benefits, limitations and Copayments and/or Coinsurances. See section 4.9.1 and your Benefit Summary. Diabetes supplies do not include insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.7.4.
- Self-administered chemotherapy drugs are covered under section 4.12.8 unless the benefits under this Prescription Drug Benefit allow for a lower out-of-pocket cost to you.
- Injectable medications received in your Provider's office are covered under section 4.3.5.
- Infusions, including infused medications, received at Outpatient Facilities are covered under section 4.7.1.
- Some prescription drugs require Prior Authorization or an exception to the Formulary in order to be covered. These may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in the Providence Health Plan Prescription Drug Formulary available on our website at www.ProvidenceHealthPlan.com 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.

4.14.2 Use of Out-of-Network Pharmacies

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

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

If your claim is approved, the Plan will reimburse you the cost of your prescription up to our Participating Pharmacy contracted rates, less your Copayment or Coinsurance if applicable. 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.

4.14.3 Prescription Drug Formulary

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

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

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

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

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

4.14.4 Prescription Drugs

Generic and Brand-Name Prescription Drugs

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

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

Affordable Care Act Preventive Drugs

Affordable Care Act (ACA) preventive drugs are medications, including contraceptives, which are listed in our Formulary and are covered at no cost when received from Participating Pharmacies as required by ACA. 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.

4.14.5 Prescription Drug Quantity

Prescription dispensing limits, including refills, are as follows:

1. Topicals, up to 60 grams;
2. Liquids, up to eight ounces;
3. Tablets or capsules, up to 100 dosage units;
4. Multi-use or unit-of-use, up to one container or package; as prescribed, not to exceed a 30-consecutive-day supply, whichever is less;
5. FDA-approved women's prescription contraceptives: up to 3-months initial dispensing, then up to 12-months subsequent dispensing at any 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 our Oregon Region Pharmacy and Therapeutics Committee. Prior Authorization is required for amounts exceeding any applicable medication dispensing limits.

4.14.6 Participating Mail-Order and Preferred Retail Pharmacies

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

1. Qualified drugs under this program will be determined by us. Not all prescription drugs are available through mail-order pharmacy.
2. Not all maintenance prescription drugs are available in 90-day allotments.

3. Copayment(s) will be applied to the quantity stated on your Benefit Summary. (Some quantity limitations and Copayments for unit of use packaging may apply).

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

4.14.7 Prescription Drug Limitations

Prescription drug limitations are as follows:

1. All drugs must be Food and Drug Administration (FDA) approved, Medically Necessary and require by law a prescription to dispense. Not all FDA-approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety and Medical Necessity within 12 months after the drug becomes available on the market for Formulary consideration.
2. Certain drugs require Prior Authorization for Medical Necessity, place of therapy, length of therapy, step therapy, number of doses or dispensing limits. Step therapy uses our pharmacy claims history to confirm if certain drugs have been tried first by a Member. If a drug has not been tried first, cannot be tried first, or if the drug history is not available, Prior Authorization is required. For some drugs, Providence Health Plan limit the amount of the drug the Plan will cover. You or your Qualified Practitioner can contact Providence Health Plan directly to request Prior Authorization. If you have questions regarding a specific drug, please call Customer Service.
3. Specialty drugs are injectable, infused, oral, topical, or inhaled therapies that often require specialized delivery, handling, monitoring and administration and are generally high cost. These drugs must be purchased through a Providence Health Plan designated specialty pharmacy. Due to the nature of these medications, specialty drugs are limited to a 30-day supply. Specialty drugs are listed in the Formulary. In rare circumstances specialty medications may be filled for greater than a 30-day supply; in these cases, additional specialty cost share(s) may apply.
4. Self-injectable medications are only covered when they are being self-administered and labeled by the FDA for self-administration; in some cases, a Prior Authorization may be required for the drug. Documentation of self-administration may also be required. Drugs labeled for self-administration that are being administered by a provider will fall to the Member's medical benefit.
5. Medications, drugs or hormones prescribed to stimulate growth are not covered, except when there is a laboratory-confirmed diagnosis of growth hormone deficiency for children through 18 years of age and when prescribed for the treatment of documented pituitary destruction in adults.
6. 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.
7. In accordance with the ACA, your Plan provides coverage in full of certain medications, including contraceptives, when these medications are purchased from Participating Pharmacies. Not all preventive medications are required to be covered

in full by the ACA. Medications in this category may be subject to medical management techniques to determine frequency, method, treatment, or setting. Brand medications for which a generic is available will not be covered in full unless the Member has received Prior Authorization from Providence Health Plan.

8. Vacation supply medication refill overrides are limited to a 30-day supply once per Calendar Year, unless otherwise provided under your Plan. Additional exceptions may be granted on a case-by-case basis.
9. A 30 day supply medication refill override will be granted if you are out of medication and have not yet received your drugs from a participating mail order pharmacy.

4.14.8 Prescription Drug 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 4.3.5);
2. Amphetamines and amphetamine derivatives except when used in the treatment of narcolepsy or attention deficit and/or hyperactivity disorder in children and adults;
3. Drugs prescribed that do not relate to the prevention or treatment of a covered illness or injury;
4. Drugs used for the treatment of fertility/infertility;
5. Fluoride, for Members over 16 years of age;
6. Drugs that are not provided in accordance with our formulary management program or are not provided according to our medical policy;
7. Drugs used in the treatment of fungal nail conditions;
8. 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;
9. Prescription drugs, including prescription combination drugs, that contain OTC products or are available in an OTC therapeutically similar form;
10. 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;
11. Drugs, which may include prescription combination drugs, placed on a prescription-only status as required by state or local law;
12. Replacement of lost or stolen medication;
13. Drugs or medicines used to treat sexual dysfunction (this exclusion does not apply to Mental Health Covered Services);
14. Drugs used in the treatment of drug-induced fatigue, general fatigue and idiopathic hypersomnia;
15. Drugs dispensed or compounded by a pharmacist that do not have at least one FDA-approved medication in therapeutic amount;
16. Drugs used for weight loss or for cosmetic purposes;
17. 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);
18. Prenatal vitamins that contain docosahexaenoic acid (DHA);
19. Drugs that are not FDA-approved or are designated as "less than effective" by the FDA (also known as "DESI" drugs);
20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC; and

21. 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.

4.14.9 Prescription Drug Disclaimer

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

5. EXCLUSIONS

In addition to those Services listed as not covered in section 4, 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;
- Are not a Covered Service or relate to complications resulting from a Non-Covered Service, except for Services provided as Emergency Care as described in section 4.5;
- Are not furnished by a Qualified Practitioner or Qualified Treatment Facility;
- Are provided by or payable under any health plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law;
- Are provided while you are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies, except to the extent provided by 38 U.S.C. § 1729 as it relates to non-military Services provided at a Veterans Administration Hospital or facility;
- Are provided while you are in the custody of any law enforcement authorities or while incarcerated, except as provided in section 3.3;
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos, books and educational programs to which drivers are referred by the judicial system, and volunteer mutual support groups;
- Are provided to yield primarily educational outcomes, except as otherwise covered under the Preventive Services benefit described in section 4.1. An outcome is "primarily educational" if the outcome's fundamental, first, or principal character is to provide you with enduring knowledge, skill, or competence through a process of repetitive positive reinforcement over an extended length of time. An outcome is "enduring" if long-lasting or permanent;
- Are performed in association with a Service that is not covered under this Plan, except Emergency Services;
- Are provided for any injury or illness that is sustained by any Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the Member. This exclusion also applies to injuries and illnesses that are the subject of a claim settlement 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. This exclusion also applies to charges applied to the deductible of such contract or insurance. Any benefits or Services provided under this Plan that are subject to this exclusion are provided solely to assist you and such assistance does not waive our right to reimbursement or subrogation as specified in section 6.3. This exclusion also applies to Services and supplies after you have received proceeds from a settlement as specified in section 6.3.3;
- Are provided in an institution that specializes in treatment of developmental disabilities, except as provided in section 4.10.2;
- Are provided for treatment or testing required by a third party or court of law which is not Medically Necessary;
- Are Experimental/Investigational;
- Are determined by us not to be Medically Necessary for diagnosis and treatment of an injury or illness;
- Are received by a Member under the Oregon Death with Dignity Act;
- Have not been Prior Authorized as required by this Plan; and
- Relate to any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member, if such Member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony or misdemeanor punishable by up to a year's imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or mental health condition);

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 4.13;
- Services for Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment (DME), except as described in section 4.9;
- Charges for Services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to, air conditioners, air purifiers, vacuum cleaners, motorized transportation equipment, escalators, elevators, tanning beds, ramps, waterbeds, hypoallergenic mattresses, cervical pillows, swimming pools, whirlpools, spas, exercise equipment, gravity lumbar reduction chairs, home blood pressure kits, personal computers and related equipment or other similar items or equipment;
- Physical therapy and rehabilitative Services, except as provided in sections 4.6.3 and 4.7.2;

- "Telephone visits" by a physician or "environment intervention" or "consultation" by telephone for which a charge is made to the patient, except as provided in section 4.3.2.
- "Get acquainted" visits without physical assessment or diagnostic or therapeutic intervention provided and online treatment sessions;
- Missed appointments;
- Non-emergency medical transportation;
- Allergy shots and allergy serums, except as provided in section 4.3.5;
- All Services and supplies related to the treatment of obesity or morbid obesity, except as provided in section 4.1.6;
- Services for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas, except as provided in section 4.1.6;
- Transportation or travel time, food, lodging accommodations and communication expenses except as provided in sections 3.6 and 4.13 and with our prior approval;
- Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
- Biofeedback, except as provided in section 4.12.16;
- Thermography;
- Homeopathic procedures;
- Comprehensive digestive stool analysis, cytotoxic food allergy test, dark-field examination for toxicity or parasites, EAV and electronic tests for diagnosis and allergy, fecal transient and retention time, Henshaw test, intestinal permeability, Loomis 24-hour urine nutrient/enzyme analysis, melatonin biorhythm challenge, salivary caffeine clearance, sulfate/creatinine ratio, urinary sodium benzoate, urine/saliva pH, tryptophan load test, and zinc tolerance test;
- Chiropractic manipulation and acupuncture, except as provided in sections 4.12.9 and 4.12.10;
- Light therapy for seasonal affective disorder, including equipment;
- Any vitamins, dietary supplements, and other non-prescription supplements, except as required by federal or Oregon state law;
- Services for genetic testing are excluded, except as provided in section 4.12.1. Genetic testing is not covered for screening, to diagnose carrier states, or for informational purposes in the absence of disease;
- Services to modify the use of tobacco and nicotine, except as provided in section 4.1.8 or when provided as Extra Values or Discounts (see our website at www.ProvidenceHealthPlan.com), where available;
- Cosmetic Services including supplies and drugs, except as approved by us and described in section 4;
- Services, including routine physical examination, immunizations and vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel;
- Non-sterile examination gloves;
- Sales taxes, handling fees and similar surcharges, as explained in the definition of UCR;

- Air ambulance transportation for non-emergency situations is not covered, except as provided in section 4.5.2;
- Treatments that do not meet the national standards for Mental Health and Substance Abuse professional practice;
- Services provided under a court order or as a condition of parole or probation or instead of incarceration which are not Medically Necessary;
- Personal growth services such as assertiveness training or consciousness raising;
- School counseling and support services, peer support services, tutor and mentor services; independent living services, household management training, and wraparound services that are provided by a school or halfway house and received as part of an 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;
- Speech therapy, physical therapy and occupational therapy services provided in connection with treatment of psychosocial speech delay, learning disorders, including mental retardation and motor skill disorders, and educational speech delay including delayed language development (except as provided in sections 4.6.3 and 4.7.2);
- Counseling related to family, marriage, sex and career including, but not limited to, counseling for adoption, custody, family planning or pregnancy, in the absence of a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis;
- Neurological Services and tests including, but not limited to, EEGs, PET, CT, MRA and MRI imaging Services, and beam scans (except as provided in section 4.4.1);
- Vocational, pastoral or spiritual counseling;
- Viscosupplementation (i.e., hyaluronic acid/hyaluronan injection);
- All Direct-to-Consumer testing products; and
- Dance, poetry, music or art therapy, except as part of an approved treatment program.

Exclusions that apply to Provider Services:

- Services of homeopaths; faith healers; or lay, unlicensed direct entry, and certified professional midwives; and
- Services of any unlicensed providers.

Exclusions that apply to Reproductive Services:

- All services related to sexual disorders or dysfunctions regardless of gender or cause (this exclusion does not apply to Mental Health Covered Services);
- All of the following services:
    - All services related to surrogate parenting, except Maternity Services as described in section 4.8;
    - All services related to in vitro fertilization, including charges for egg/semen harvesting and storage;

- All services related to artificial insemination, including charges for semen harvesting and storage;
- All services and prescription drugs related to fertility preservation;
- Diagnostic testing and associated office visits to determine the cause of infertility;
- All of the following services when provided for the sole purpose of diagnosing and treating an infertile state or artificial reproduction:
  - Physical examination;
  - Related laboratory testing;
  - Instruction;
  - Medical and surgical procedures, such as hysterosalpingogram, laparoscopy, or pelvic ultrasound; and
  - Related supplies and prescriptions.

For the purpose of this exclusion:

- Infertility or infertile means the failure to become pregnant after a year of unprotected intercourse or the failure to carry a pregnancy to term as evidenced by three consecutive spontaneous abortions.
- Artificial reproduction means the creation of new life other than by the natural means.

- Termination of pregnancy, unless there is a severe threat to the mother, or if the life of the fetus cannot be sustained;
- Reversal of voluntary sterilization;
- Male condoms and other over-the-counter birth control products for men; 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; and
- Orthoptics and vision training; and
- Services for routine eye care and vision care, vision exams/screenings, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in sections 4.1.1, 4.1.5, 4.5.3 and 4.9.2.

Exclusions that apply to Hearing Services:

- Replacement of lost or broken hearing aids are generally not covered, except for one time if a loss or damage claim is made within the first year of purchase;
- Repair of hearing aids outside of the warranty period are not covered. Repair needs during your warranty period should be discussed with your provider;
- Hearing aids prescribed and ordered prior to coverage, or prescribed or ordered after termination of coverage, whichever occurs first; and
- Hearing aids, hearing therapies and/or devices, except as provided in section 4.12.13.

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 us and described in sections 4.12.6;
- Services for orthognathic surgery, except as approved by us and described in section 4.12.6;
- Services to treat temporomandibular joint syndrome (TMJ), except as provided in section 4.12.7; and
- Dentures and orthodontia, except as provided in sections 4.12.6.

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 4.9.2.

Exclusions that apply to Prescription Drugs, Medicines and Devices:

- In addition to the exclusions listed in section 4.14.8; 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.

6. 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.

6.1 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 is not a bill. An EOB explains how Providence Health Plan processed your claim, and will assist you in paying the appropriate Member responsibility to your provider. Copayment or Coinsurance amounts, Deductible amounts, services or amounts not covered and general information about our processing of your claim are explained on an EOB.

Time Frames for Processing Claims

If 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 if 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, you will be sent a separate request for the information and you will have 45 days to submit the additional information. Once the additional information from you 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 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 additional information is needed to process the request, Providence Health Plan will provide written notice to the Member and the provider within two business days of receiving the Prior Authorization request. The Member and the provider will have 15 days to submit the additional information. Within two business days of receipt of the additional information, Providence Health Plan will complete 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 24 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.

6.1.1 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 (i.e., a Coordinated Care Organization) will be made in accordance with ORS 743B.470, which establishes payment requirements for claims submitted by the Oregon state Medicaid agency.

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

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

6.1.2 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.

6.2 COORDINATION OF BENEFITS

This Coordination of Benefits (COB) section applies when a Member has health care coverage under more than one Plan. The term "Plan" is defined below for the purposes of this COB section. The order of benefit determination rules 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.

6.2.1 Definitions Relating to Coordination of Benefits

Plan

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

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

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

This Plan

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

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

When This Plan is primary, Providence Health Plan determines payment for benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, Providence Health Plan determines benefits after those of another Plan and

may reduce the benefits payable 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.

6.2.2 Order of Benefit Determination Rules

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

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

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

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

coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

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

iv. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the Dependent child are as follows:

- The Plan covering the Custodial parent, first;
- The Plan covering the spouse of the Custodial parent, second;
- The Plan covering the non-custodial parent, third; and then
- The Plan covering the Dependent spouse of the non-custodial parent, last.

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

d) For a Dependent child:

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

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

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

agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

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

6.2.3 Effect on the Benefits of This Plan

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

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

6.2.4 Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply this COB section and to determine benefits payable under This Plan and other Plans. Providence Health Plan may get the facts needed from, or give them to, other organizations or persons for the purpose of applying this section and determining benefits payable under This Plan and other Plans covering a Member claiming benefits. Providence Health Plan 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 Providence Health Plan needs to apply this section and determine benefits payable.

6.2.5 Facility of Payment

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

6.2.6 Right of Recovery

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

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

6.2.7 Coordination with Medicare

In all cases, coordination of benefits with Medicare will conform with federal statutes and regulations. Medicare means Title XVIII of the Social Security Act, as enacted or amended. Medicare eligibility and how This Plan determines benefit limits 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.

6.3 THIRD-PARTY LIABILITY/SUBROGATION

The following provisions will apply when you or any other Member has received Services for a condition for which one or more third parties may be responsible. "Third party" means any person other than the Member (the first party to the provisions of this Plan), 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 us 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 9.4. 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 the Plan under these provisions.

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

Third-party liability refers to claims that are in whole or part the responsibility of someone besides the 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, the Plan 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 the Plan makes claim payments 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 the 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, the Plan is 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 has a security interest in and lien upon any recovery to the extent of the amount of benefits paid by the Plan and for the Plan's expenses in obtaining a recovery. If the Member should either decline to pursue a claim against a third party that the Plan believes is warranted or refuse to cooperate with the Plan in any third party claim that the Member does pursue, the Plan has 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, the Plan needs 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 Providence Health Plan office. A Providence Health Plan employee who specializes in third-party liability/subrogation can discuss these procedures and what you or the Member needs to do.

6.3.2 Proceeds of Settlement or Recovery

Subject to paragraph 6.3.4 below, if for any reason 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 the Plan 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 the Plan for the condition, calculated using the 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 the Plan's first priority to this repayment and assigns to us 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 the Plan. 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 the Plan directly from the settlement or recovery in the amount provided by this section.

The Member must complete the Plan's trust agreement, by which the Member and any Member's attorney (or other agent) must confirm the obligation to reimburse the Plan 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 the Plan. The agreement must remain in effect and the Plan 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 the Plan to exercise the Plan's rights under this section, it serves as a reminder to the Member and directly obligates any Member's attorney to act in accord with the Plan's rights.

6.3.3 Suspension of Benefits and Reimbursement

Subject to paragraph 6.3.4 below, after the Member has received proceeds of a settlement or recovery from the third party, the Member is responsible for payment of all medical expenses for the continuing treatment of the illness or injury that 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 the Plan as required by this section, the Plan is entitled to offset future benefits otherwise payable under this Plan, or under any future contract or plan with Clackamas County, 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 the 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 the 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 the Plan has not approved in advance. In no event shall the amount reimbursed to the Plan be less than the maximum permitted by law.

6.3.4 Special Rules for Motor Vehicle Accident Cases

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

Before the Plan will be entitled to recover 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.

7. PROBLEM RESOLUTION

7.1 INFORMAL PROBLEM RESOLUTION

All employees of Providence Health Plan share responsibility for assuring Member satisfaction. If you have a problem or concern about your coverage, including benefits or Services by In-Network Providers or payment for Services by Out-of-Network Providers, please ask for Providence Health Plan's 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, Providence Health Plan will make efforts to accommodate your requirements. Please contact Customer Service for help with whatever special needs you may have.

7.2 MEMBER GRIEVANCE AND APPEAL

Definitions:

Adverse Benefit Determination

An Adverse Benefit Determination means a:

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

Appeal

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

Authorized Representative

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

Concurrent Care

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

Grievance

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

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

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

7.2.1 Your Grievance and Appeal Rights

If you disagree with Providence Health Plan's decision about your medical bills or health care services, you have the right to an 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 Providence Health Plan will consider that information in the 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 received 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 Providence Health Plan's 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, you will be notified of the 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 reconsideration of the decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. Providence Health Plan will then notify you of the reconsideration decision within 24 hours of receiving your request.

7.2.2 Internal Grievance or Appeal

You must file your internal Grievance or Appeal within 180 days of the date on the notice of the initial Adverse Benefit Determination, or that initial determination will become final. Please advise Providence Health Plan of any additional information that you want considered in 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 for the review process. Your Grievance or Appeal will be reviewed by Providence Health Plan staff not involved in the initial determination. You may present your case in writing. Once a final determination is made you will be sent a written explanation of the decision.

7.2.3 External Review

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

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

The Plan pays for all costs for the handling of external review cases and Providence Health Plan administers these provisions in accordance with the insurance laws and regulations of the State of Oregon. **If we do not comply with the IRO decision, you have the right to sue us under applicable Oregon law.**

7.2.4 How to Submit Grievances or Appeals and Request Appeal Documents

To submit your Grievance or Appeal or requests for External Review, you may contact Customer Service at 503-574-7500 or 800-878-4445. If you are hearing impaired and use a Teletype (TTY) Device, please call the TTY line at 711. Written Grievances or Appeals should be sent to:

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

You may fax your Grievance or Appeal 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

If your plan is governed by ERISA, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). If your plan is not governed by ERISA, you may contact the Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789.

8. 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 and your Employer must provide Providence Health Plan with evidence of eligibility as requested.

8.1 EMPLOYEE ELIGIBILITY AND ENROLLMENT

8.1.1 Employee Eligibility Date

An employee is eligible for coverage as specified in the Eligible Employee definition.

8.1.2 Employee Effective Date

Coverage begins for an Eligible Employee as specified in the Effective Date of Coverage definition.

8.1.3 Employee Enrollment

The Eligible Employee must enroll on forms (paper or electronic) provided and/or accepted by Clackamas County. To obtain coverage, an Eligible Employee must enroll within 30 days to enroll after becoming eligible. An enrolled Eligible Employee is referred to as the Subscriber.

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.

In certain situations, you and/or your Eligible Family Dependents may qualify to enroll during a special enrollment period. See section 8.3 for additional information.

8.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

8.2.1 Eligibility Date

Coverage begins for each Eligible Family Dependent on:

1. The Effective Date of Coverage for the Subscriber if the individual is an Eligible Family Dependent on that date;
2. For any Eligible Family Dependents acquired on the date of the Subscriber's marriage, on the first day of the calendar month following receipt of the enrollment request, within 60 days of the Subscriber's marriage;
3. The date of birth of the biological child of the Subscriber or Spouse;
4. The date a child is placed with the Subscriber or Spouse for the purpose of adoption by the Subscriber or Spouse;
5. The date the Subscriber or Spouse is required to provide health coverage to a child under a qualified medical child support court or administrative order; or
6. The date on which legal guardianship status begins.

8.2.2 Additional Requirements for Eligible Family Dependent Coverage

An Eligible Employee may cover Eligible Family Dependents ONLY if the Eligible Employee is also covered, and Clackamas County receives the completed enrollment form requesting Dependent coverage.

8.2.3 Eligible Family Dependent Enrollment

You must enroll Eligible Family Dependents on forms provided and/or accepted by Clackamas County. No Eligible Family Dependent will become a Member until Clackamas County approves that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within 30 after becoming eligible as indicated in section 8.2.1 (see section 8.2.4 regarding newborn and adopted children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 8.3.

8.2.4 Newborn Eligibility and Enrollment

A newborn or adopted child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption as long as enrollment occurs within 60 days from birth or placement and additional Premium, if any, is paid to Clackamas County. 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 8.2.3 and 8.3.

8.2.5 Open Enrollment Period

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

8.2.6 Changes in Eligibility

When an eligibility change occurs, you need to make sure Clackamas County is notified of the change. Address changes can be made by contacting Clackamas County Benefits & Wellness.

For the following changes, you, as the Subscriber, must obtain an enrollment form from Clackamas County's benefit office. You need to submit this form to your Employer for you and all your Eligible Family Dependents when:

- You marry and wish to enroll your new Spouse;
- A Dependent's limiting age occurs; or
- You or one of your Dependents has a legal name change.

If you have questions regarding eligibility changes, please contact Clackamas County Benefits & Wellness.

8.2.7 Members No Longer Eligible for Coverage

If you divorce or are legally separated, your Spouse is no longer eligible for coverage as a Dependent. You must disenroll your Spouse as a Dependent from your Plan at the time the divorce or legal separation is final. Your Spouse's children will be able to continue coverage under the Plan so long as the children continue to qualify as your Eligible Family Dependents.

You must inform Clackamas County of these changes by completing a new enrollment form. Check with Clackamas County's benefits office or contact Customer Service 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 section 10. Ask Clackamas County or call Customer Service for continuation coverage eligibility information.

8.3 SPECIAL ENROLLMENT PERIODS

If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your Spouse) during a previous enrollment period (as stated in sections 8.1 and 8.2), you may be eligible to enroll yourself or the Eligible Family Dependent during a "special enrollment period" provided that you request enrollment within 60 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
- Enroll in any benefit option offered by the Employer for which the Subscriber and Eligible Family Dependent is eligible.

8.3.1 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, the Plan 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 the Plan 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 benefits; and the individual applies for coverage under this Plan within 60 days after the claim is denied.

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

8.3.2 New 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, birth, adoption or placement for adoption; the Plan 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 60 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.

Effective Date:

- in the case of marriage, on the first day of the calendar month following Clackamas County's receipt of the enrollment request, or on an earlier date as agreed to by Clackamas County; 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.

8.3.3 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 or minor child under your Health Benefit Plan, the Plan 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 60 days after the issuance of the court order.

Effective Date: The date specified in the court order.

8.3.4 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 arrangement, the Plan 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.

8.4 LEAVE OF ABSENCE AND LAYOFFS

A Subscriber on leave of absence or layoff status may continue to be covered under this Plan as though actively at work for a period of time, if any, as stated in the Eligible Employee definition. An Employee who returns to work as an Eligible Employee after coverage has lapsed must re-enroll for coverage as specified in section 8.1.3.

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), is administered in accordance with those Acts and this Summary Plan Description.

9. TERMINATION OF MEMBER COVERAGE

9.1 TERMINATION DATES

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 Clackamas County;
3. The last day of the coverage period in which a Subscriber no longer qualifies as a Subscriber, as stated in the Summary Plan Description;
4. The date a Member enters full-time military, naval or air service, except as provided under federal USERRA requirements;
5. The last day of the coverage period in which a Subscriber retires;
6. 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;
7. For a Family Member, the date the Subscriber's coverage terminates;
8. For a Family Member, the last day of the month in which the individual no longer qualifies as an Eligible Family Dependent;
9. For any benefit, the date the benefit is deleted from this Plan;
10. For a Member, the date of disenrollment from this Plan as described in section 9.4;
11. For a Member, the date any fraudulent information is provided; or
12. For a Member, the date we discover any breach of contractual duties, conditions or warranties, as determined by us.
13. For a Subscriber that is a Non-Medicare Eligible Early Retiree, the last day of the month in which the Retiree becomes eligible for Medicare.

You and the Employer are responsible for advising Clackamas County 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 Clackamas County.

See section 7, Problem Resolution, for your Grievance and Appeal rights.

9.2 TERMINATION AND RESCISSION OF COVERAGE DUE TO FRAUD OR ABUSE

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

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

9.3 NON-LIABILITY AFTER TERMINATION

Upon termination of this Plan, Clackamas County shall have no further liability beyond the effective date of the termination unless the Member continues, without lapse of membership, under another Clackamas County plan.

9.4 DISENROLLMENT FROM THIS PLAN

"Disenrollment" means that your coverage under this Plan is terminated 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 Clackamas County or Providence Health Plan employees; or
4. You have allowed a non-Member to use your Member ID Card to obtain Services.

9.5 NOTICE OF CREDITABLE COVERAGE

Providence Health Plan will provide upon request written certification of the Member's period of Creditable Coverage when:

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

9.6 CLACKAMAS COUNTY'S RIGHT TO TERMINATE OR AMEND PLAN

Clackamas County 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 Clackamas County.

10. 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 and which are generally outlined below. Please contact Clackamas County as soon as possible for details if you think you may qualify for group COBRA or state continuation coverage.

10.1 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.

10.1.1 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.

10.1.2 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.

10.1.3 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 who is properly enrolled under the terms of this Plan during the COBRA continuation period will be a qualified beneficiary.

10.1.4 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 Clackamas County 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 Clackamas County 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.

10.1.5 Type of COBRA Continuation Coverage

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

10.1.6 COBRA Election Rights

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

10.1.7 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 Clackamas County 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.

10.1.8 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 their 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 Clackamas County 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 Dependent child 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.

10.1.9 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.

10.1.10 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/.

10.1.11 When COBRA Continuation Coverage Ends

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

- Clackamas County 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;
- 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.

11. MEMBER RIGHTS AND RESPONSIBILITIES

11.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES

As a Member of Providence Health Plan, you should know what to expect from Providence Health Plan, as well as what Providence Health Plan asks from you. Nobody knows more about your health than you and your doctor. Providence Health Plan takes 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. Providence Health Plan wants you to have a positive experience, and 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, the providers, and the benefits and Services you have available to you as a Member.
- Receive information that helps you select a Qualified Practitioner whom you trust and with whom you feel comfortable.
- A candid discussion of appropriate or Medically Necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Receive information and clinical guidelines from your health care provider or your health plan that will enable you to make thoughtful decisions about your health care.
- Actively participate in decisions that relate to your health and your medical care through discussions with your health care provider or through written advance directives.
- Have access to medical Services that are appropriate for your needs.
- Express a concern or an Appeal and receive a timely response from Providence Health Plan.
- Have your claims paid accurately and promptly.
- Request a review of any service not approved, and to receive prompt information regarding the outcome.
- Be informed about and make recommendations regarding Providence Health Plan's member rights and responsibilities policy.
- Refuse care from specific providers.

Members have the responsibility to:

- Read and understand the information in and the terms of your Plan. Neither the Plan nor Providence Health Plan will have liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact Customer Service. Providence Health Plan will assist you in understanding and complying with the terms of the Plan.
- Talk openly with your physician or provider, understand your health problem and work toward a relationship built on mutual trust and cooperation.
- Develop mutually agreed upon treatment goals with your Qualified Practitioner, to the degree possible, and follow treatment plans and instructions.
- Supply to the extent possible information Providence Health Plan 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 Customer Service know if you have concerns or if you feel that any of your rights are being compromised, so that Providence Health Plan can act on your behalf.
- Call or write within 180 days of Service if you wish to request a review of Services provided or Appeal a Providence Health Plan decision.
- Notify Customer Service if your address changes.

Providence Health Plan has the responsibility to:

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

11.2 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 Clackamas County's Group Plan, you are entitled to certain rights and protections under Oregon law, which provides that all Plan participants are entitled to:

1. **Receive from Providence Health Plan information maintained about you by your Employer's group plan**
    - You are entitled within 30 days to access to recorded personal information, 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 10.1.
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 7, the Plan offers 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 7.2 of this Summary Plan Description. If the Member elects to seek external review under section 7.2.4, both the Plan and the Member will be bound by the Independent Review Organization (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 7.2.

    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 or an arbitrator, neither party shall under any circumstance be liable to the other for any special, incidental, or consequential damages, or for any tort liability (including any punitive or exemplary damages), in any way related to this Plan.

12. 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.

12.1 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 Clackamas County has determined satisfies the QMSCO standards set forth below.

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

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

12.2 NOTICE UPON RECEIPT OF ORDER

Upon the receipt of any Order, Clackamas County 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.

12.3 NOTICE OF DETERMINATION

Within a reasonable period after its receipt of the Order, Clackamas County 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, the Order will not be considered to be a QMCSO.

12.4 ENROLLMENT OF ALTERNATE RECIPIENT

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

12.5 COST OF COVERAGE

An Alternate Recipient will be treated as having been 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.

12.6 REIMBURSEMENT OF PLAN EXPENSES

Unless the terms of the Order provide otherwise, any payments to be from the Plan as reimbursement for group health expenses paid either by the Alternate Recipient, or by the custodial parent or legal guardian of the Alternate Recipient, will not be paid to the 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.

12.7 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.

12.8 TREATMENT OF NATIONAL MEDICAL SUPPORT NOTICE

If Clackamas County 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 Clackamas County to satisfy the QMCSO standards prescribed above, then the National Notice shall be deemed to be a QMSCO respect to such child.

Clackamas County, upon determining that the National Notice is a QMSCO, 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.

Clackamas County 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.

13. GENERAL PROVISIONS

13.1 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.

13.2 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.

13.3 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.

13.4 FAILURE TO PROVIDE INFORMATION OR PROVIDING INCORRECT OR INCOMPLETE INFORMATION

Members warrant that all information contained in applications, questionnaires, forms, or statements submitted to Clackamas County and to Providence Health Plan to be true, correct, and complete. If a Member willfully fails to provide information required to be provided under this Plan or knowingly provides incorrect or incomplete information, then the Member's rights may be terminated. See section 9.4.

13.5 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.

13.6 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.

13.7 LEGAL ACTION

No civil action may be brought under state or federal law to recover benefits from the Plan until receipt of a final decision under the Member Grievance and Appeal process specified in section 7.2 of the Summary Plan Description, unless the Member's benefits under the Plan are subject to the Employee Retirement Income Security Act (ERISA), in which case the Member is permitted either to bring a civil action under ERISA in federal court after receiving a decision from the First Level of Appeal or to bring such an action after receipt of a final grievance decision. An appeal from a final Grievance decision may lie with an Independent Review Organization (IRO). In the event a right to IRO review exists and the Member elects to seek such review, the IRO decision will be binding and final, as indicated in section 7.2.4. No civil action under ERISA or otherwise 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 7.2. If ERISA does not apply (see section 11.2) the action must be brought in Oregon state court, either in the Member's county of residence or such other county as mutually agreed upon between Member and the Plan. In general, ERISA applies if this is an employer-sponsored plan, other than a government plan or church plan.

13.8 LIMITATIONS AND 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 Clackamas County shall be paid solely in accordance with the terms and provisions of such plan, and nothing in this Plan shall operate or be construed in any way to modify, amend, or affect the terms and provisions of such other plan.

13.9 MEMBER RESPONSIBILITY

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

13.10 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.

13.11 NON-TRANSFERABILITY OF BENEFITS

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

13.12 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 Clackamas County. No shareholder, director, officer, or employee of Clackamas County 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.

13.13 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 Clackamas County nor Providence Health Plan is liable for any claim or demand due to damages arising out of, or in any manner connected with, any injuries suffered by you while receiving such Services.

13.14 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.

13.15 NOTICE

Any notice required of Clackamas County or Providence Health Plan under this Plan shall be deemed to be sufficient if mailed to the Subscriber at the address appearing in 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, P.O. Box 3125, Portland, OR 97208.

13.16 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 6.1.1 regarding timely submission of claims.)

13.17 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. PHP'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 Clackamas County and Providence Health Plan.

13.18 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.

13.19 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 our 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.

13.20 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.

13.21 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 Clackamas County to deduct the overpayment from future benefit payments under this Plan.

13.22 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.

13.23 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.

13.24 SUGGESTIONS

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

13.25 VETERANS' RIGHTS

The Plan will provide benefits to employees 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) An employee who takes unpaid military leave, or who separates from the employment of Clackamas County 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 10. 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 employee's absence for the purpose of performing military service begins; or
    2. The date the employee fails to timely return to employment or reapply for a position with Clackamas County upon the completion of such military service.

13.26 WORKERS' COMPENSATION INSURANCE

This Plan is not in lieu of, and does not affect, any requirement for coverage under any workers' compensation act or similar law.

14. PLAN ADMINISTRATION

14.1 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. 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.

14.2 PLAN INFORMATION

Plan Name: Clackamas County General County Employees Open Option Plan
Plan No. 100112
Employer ID No. 936002286

14.3 PLAN DATES

The effective date of the Plan is January 1st and ends on December 31st.

14.4 PLAN SPONSOR INFORMATION

Clackamas County
Benefits & Wellness Division
Public Services Building
2051 Kaen Road, Suite 310
Oregon City, OR 97045
503-655-8459

14.5 ADMINISTRATIVE SERVICES PROVIDED BY

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

14.6 AGENT FOR SERVICE OF LEGAL PROCESS

Clackamas County
Office of County Counsel
2051 Kaen Rd.
Oregon City, OR 97045

14.7 ADMINISTRATIVE SERVICES

The Employer 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 are specified in the Administrative Services Agreement that has been executed by the Employer and Providence Health Plan.

14.7.1 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.

14.8 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.

14.9 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.

14.10 AMENDMENT OR TERMINATION OF PLAN

14.10.1 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.

14.10.2 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 Chair of the Board of County Commissioners or their designee shall be conclusive evidence of the adoption and effectiveness of the instrument.

14.10.3 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.

14.11 PROTECTED HEALTH INFORMATION

14.11.1 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 PHI obtained from Providence Health Plan 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:

(k) Directors of Human Resources;

1. Benefit Managers;
2. Benefit Analysts;
3. Benefit Specialists; and
4. 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.

14.11.2 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 14.11.1(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.

15. DEFINITIONS

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

Adverse Benefit Determination
See section 7.

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

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

Annual
Annual means once per Calendar Year.

Appeal
See section 7.

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

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

Authorized Representative
See section 7.

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

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

Chemical Dependency
Chemical Dependency 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 Abuse does not mean an addiction to, or dependency on, tobacco, tobacco products or foods.

Clackamas County
Clackamas County means the entity that is the Sponsor of this Plan.

Clackamas County General County Employees Open Option Plan
Clackamas County General County Employees Open Option Plan means this Summary Plan Description and includes the provisions of the Benefit Summaries and any Endorsements, amendments and addendums that accompany this document.

Cochlear Implant
See section 4.12.14.

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. Your Coinsurance for a Covered Service is shown in the Benefit Summary and is a percentage of the charges for the Covered Service. Your Coinsurance will usually be less when you receive Covered Services from an In-Network Provider.

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 section 4;
2. Medically Necessary;
3. Not listed as an Exclusion in the Benefit Summary or in sections 4 and 5; 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 3.11.1.

Dependent

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

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 with a member of the same sex; and
    - Has legally registered a Declaration of Domestic Partnership and obtained a Certificate of Registered Domestic Partnership in accordance with Oregon state law.
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 4.1.3).

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

Eligibility Waiting Period
Eligibility Waiting Period means the period of employment, as specified in the Eligible Employee definition, that an otherwise Eligible Employee must complete before coverage will begin under this Plan. The Eligibility Waiting Period will not exceed 90 days. When the Eligibility Waiting Period is 90 days, coverage is effective on the 91st day. If an employee enrolls on a special enrollment date, any period before such special enrollment is not an Eligibility Waiting Period.

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 8.1.

1. Employment Status: Permanent. (On-call, temporary, substitute, and seasonal employees are not eligible.)
2. Employment Category/Class: Open Option General County Employees, COBRA participants, Non-Medicare Eligible Early Retirees, and Job Share.
3. Work Hours: Regularly scheduled for at least 20 hours per week (18.75 hours for Job Share). Not applicable to COBRA participants and Non-Medicare Eligible Early Retirees.

4. Eligibility Waiting Period: Two months.* A new Eligibility Waiting Period does not apply if an employee returns to work in eligible status from a period of layoff or leave of absence, provided that such period did not exceed 180 days. The Eligibility Waiting Period is also waived if an employee has continuously participated in COBRA continuation coverage during the layoff period and is rehired within 18 months from the date of layoff. (*Note: Effective July 1, 2021, the Eligibility Waiting Period for new employees hired on or after this date will be the first of the month following date of hire.)
5. Effective Date of Coverage: Active: First of the month following completion of the Eligibility Waiting Period. COBRA: First day following loss of Active coverage. Early Retiree: First of the month following retirement.
6. Location: Employees who work or reside in Oregon.
7. Leave of Absence Status: An otherwise Eligible Employee on an Employer-approved Leave of Absence shall remain eligible during the first six months of leave of absence. Absences extending beyond this period are subject to the COBRA provisions of this Summary Plan Description.
8. Layoff/Rehire: If the Eligible Employee is rehired within six months, the Eligibility Waiting Period is waived.
9. Retirement Status: Non-Medicare eligible retired employees are eligible.

Eligible Family Dependent

Eligible Family Dependent means:

1. The legally recognized Spouse or Domestic Partner of a Subscriber;
2. In relation to a Subscriber, the following individuals:
    a) A biological child, step-child, or legally adopted child;
    b) An unmarried grandchild for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support;
    c) A child placed for adoption with the Subscriber or Spouse;
    d) An unmarried individual for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support; and
    e) A child for whom the Subscriber or Spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law.

Placement for adoption means the assumption and retention by a Subscriber or Spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption). Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.

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;
2. Incapable of self-sustaining employment prior to the limiting age; and
3. Unmarried.

Proof of incapacity must be provided to us 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. Thereafter, Providence Health Plan 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 Providence Health Plan, the individual's coverage will not continue beyond the last date of eligibility.

See section 8.2.4 for information on when and how to add a newborn to the Plan.

Emergency Medical Condition
See section 4.5.1.

Emergency Medical Screening Exams
See section 4.5.1.

Emergency Services
See section 4.5.1.

Employer
Employer means Clackamas County, an Oregon employer, and the Plan Sponsor.

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

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

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental Health and substance use disorder (Substance Abuse) services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including dental and vision care.

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

Experimental/Investigational
Experimental/Investigational means Services for which current, prevailing, evidence-based, peer-reviewed medical literature does not demonstrate the safety and effectiveness of the Service for treating or diagnosing the condition or illness for which its use is proposed. In

determining whether Services are Experimental/Investigational the Plan considers a variety of criteria, which include, but are not limited to, whether the Services are :

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

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

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

Fiduciary
Fiduciary means a person entrusted to act on behalf of the Plan, consistent with the duties and obligations of plan administration as set forth under applicable law.

Grievance
See section 7.

Global Fee
See section 4.13.2

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 Employee Retirement Income Security Act (ERISA).

Hearing Aid
See section 4.12.14.

Hearing Assistance Technology
See section 4.12.14.

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 Abuse or Mental Health disorders.

In-Network

In-Network means the level of benefits specified in the Benefit Summary and 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, Hospital, Qualified Practitioner, Qualified Treatment Facility, Skilled Nursing Facility, or Pharmacy that has a written agreement with Providence Health Plan to participate as a health care provider for this Plan. For Native American Indian and Alaskan Native Members, Covered Services obtained through Indian Health Services are considered to be Covered Services obtained from an In-Network Provider.

Ineligible Person

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

Late Enrollee

Late Enrollee means a person eligible to enroll under a Special Enrollment Period, as described in section 8.3.

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

Non-Medicare Eligible Early Retiree
Non-Medicare Eligible Early Retiree means a Subscriber who retires from employment with Clackamas County and is eligible to enroll in this Plan.

Open Enrollment Period
Open Enrollment Period means a period during each Plan Year, as established by Clackamas County, 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 the Benefit Summary and 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 for this Plan.

Out-of-Pocket Maximum
See section 3.11.2.

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

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

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

Plan
Plan means the Clackamas County group health plan, as set forth in this document, the Summary Plan Description, and includes the provisions of any Benefit Summary 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.

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 Qualified Practitioner specializing in obstetrics or gynecology; a nurse practitioner; a

certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider.

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

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 Providence Health Plan's 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, additional information may be required about the Member's condition and/or the Services requested. Providence Health Plan 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 Plan. Services that require Prior Authorization are shown in section 3.5. 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 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 corrects a congenital deformity or anomaly that results in a functional impairment.

Retail Health Clinic

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

Service
Service means a health care related procedure, surgery, consultation, advice, diagnosis, referral, treatment, supply, medication, prescription drug, device or technology that is provided to a Member by a Qualified Practitioner.

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 or non-Medicare Eligible Early Retiree of Clackamas County who is eligible for benefits and is properly enrolled in accordance with the provisions of this Summary Plan Description.

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

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

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

Usual, Customary and Reasonable (UCR)
When a Service is provided by an In-Network Provider, UCR means charges based on the fee that 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 determined, in Providence Health Plan's reasonable discretion, based on the lesser of:

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

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

Virtual Visit

Virtual Visit means a visit with a Provider using secure internet technology:

- Phone and Video Visit:
  Phone and Video Visit means a Medically Necessary and appropriate consultation through phone and video with an In-Network or Out-of-Network Provider using Providence Health Plan approved secure technology. A Phone and Video Visit must relate to the treatment of a covered illness or injury (see also section 4.3.2).
- Web-direct Visit:
  Web-direct Visit means a Medically Necessary consultation with an In-Network Provider utilizing an online questionnaire to collect information and diagnose common conditions such as cold, flu, sore throat, allergy, ear ache, sinus pain, or UTI (see also section 4.3.2).

Women's Health Care Provider

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

16. NON-DISCRIMINATION STATEMENT

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

Providence Health Plan and Providence Health Assurance:

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

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

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

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

Language Access Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 Clackamas County's self-funded Employee Health Benefit Plan, Clackamas County General County Employees Open Option 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 Clackamas County'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, 2021.

By: _____

Printed Name: _____

Title: _____

Company: _____

Date: _____

Administered by

PROVIDENCE
Health Plan

Our Mission

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

Our Values

Compassion | Dignity | Justice | Excellence | Integrity

Questions? We're here to help.

Speak to one of our Customer Service representatives at 503-574-7500 or 800-878-4445 (TTY: 771); 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.

©2020 Providence Health Plan. All rights reserved.

Clackamas Co GCE Open Option SPD
Effective January 01, 2021
Administered by Providence Health Plan

2021 Summary Plan Description

General County Employees Personal Option

TABLE OF CONTENTS

1. INTRODUCTION 1

1.1 KEY FEATURES OF YOUR CLACKAMAS COUNTY GENERAL COUNTY EMPLOYEES PERSONAL OPTION PLAN 2

2. WELCOME TO PROVIDENCE HEALTH PLAN 3

2.1 CLACKAMAS COUNTY GENERAL COUNTY EMPLOYEES PERSONAL OPTION PLAN 3
2.2 SUMMARY PLAN DESCRIPTION 3
2.3 CUSTOMER SERVICE 4
2.4 REGISTERING FOR A MYPROVIDENCE ACCOUNT 4
2.5 YOUR MEMBER ID CARD 4
2.6 PROVIDENCE NURSE ADVICE LINE 5
2.7 WELLNESS BENEFITS 5
2.8 PRIVACY OF MEMBER INFORMATION 7

3. HOW TO USE YOUR PLAN 9

3.1 IN-NETWORK PROVIDERS 9
3.1.1 Nationwide Network of In-Network Providers 9
3.1.2 Choosing an In-Network Provider 9
3.1.3 Indian Health Services Providers 9
3.2 THE ROLE OF A PRIMARY CARE PROVIDER 10
3.2.1 Primary Care Providers 10
3.2.2 Established Patients with Primary Care Providers 10
3.2.3 Selecting a New Primary Care Provider 10
3.2.4 Changing Your Primary Care Provider 11
3.2.5 Office Visits 11
3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS 12
3.4 MOVING INTO OR OUT OF THE SERVICE AREA 13
3.5 OUT-OF-AREA DEPENDENTS 13
3.5.1 Out-of-Area Dependent Enrollment 14
3.5.2 Out-of-Area Dependent Coverage 14
3.5.3 Out-of-Area Dependents and Change of Status 14
3.5.4 Out-of-Area Dependents Prior Authorization 14
3.6 NOTICE OF PROVIDER TERMINATION 14
3.7 PRIOR AUTHORIZATION 15
3.8 TRAVEL EXPENSE REIMBURSEMENT 16
3.9 MEDICAL COST MANAGEMENT 17
3.9.1 Coverage of New Technology and New Application of Existing Technology 17
3.10 MEDICALLY NECESSARY SERVICES 18
3.11 APPROVED CLINICAL TRIALS 19
3.12 HOW BENEFITS ARE APPLIED 19
3.13 DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS 19
3.13.1 Understanding Deductibles 19
3.13.2 Understanding Out-of-Pocket Maximums 20

4. COVERED SERVICES 22

4.1 PREVENTIVE SERVICES 22
4.1.1 Physical Examinations and Well-Baby Care 22
4.1.2 Immunizations and Vaccinations 23
4.1.3 Prostate Cancer Screening Exams 23
4.1.4 Colorectal Cancer Screening Exams 23
4.1.5 Preventive Services for Members with Diabetes 24
4.1.6 Diabetes Self-Management Education Program 24
4.1.7 Nutritional Counseling 24
4.1.8 Tobacco Use Cessation Services 24
4.2 WOMEN'S PREVENTIVE HEALTH CARE SERVICES 24
4.2.1 Gynecological Examinations 25
4.2.2 Mammograms 25
4.2.3 Breastfeeding Counseling and Support 25
4.2.4 Family Planning Services 25
4.3 PROVIDER SERVICES 25
4.3.1 Office Visits, Inpatient and Outpatient Hospital Visits, and Home Visits 25
4.3.2 Virtual Visits 26
4.3.3 E-mail Visits 26
4.3.4 Telemedical Services 27
4.3.5 Allergy Shots, Allergy Serums, Injectable and Infused Medications 28
4.3.6 Administration of Anesthesia and Surgical Procedures 28
4.3.7 Immediate Care 28
4.3.8 Retail Health Clinics 28
4.4 DIAGNOSTIC SERVICES 29
4.4.1 Diagnostic Pathology, Radiology Tests, High Tech Imaging and Diagnostic Procedures 29
4.4.2 Sleep Study Services 29
4.5 EMERGENCY CARE AND URGENT CARE SERVICES 29
4.5.1 Emergency Care 29
4.5.2 Emergency Medical Transportation 31
4.5.3 Emergency Eye Care Services 31
4.5.4 Emergency Detoxification Services 31
4.5.5 Urgent Care 31
4.6 INPATIENT HOSPITAL AND SKILLED NURSING FACILITY SERVICES 32
4.6.1 Inpatient Hospital Services 32
4.6.2 Skilled Nursing Facility 33
4.6.3 Inpatient Rehabilitative Care 33
4.6.4 Inpatient Habilitative Care 33
4.6.5 Observation Care 34
4.7 OUTPATIENT SERVICES 34
4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy 34
4.7.2 Outpatient Rehabilitative Services 34
4.7.3 Outpatient Habilitative Services 35
4.8 MATERNITY SERVICES 35

4.9 MEDICAL SUPPLIES, MEDICAL APPLIANCES, PROSTHETIC AND ORTHOTIC DEVICES AND DURABLE MEDICAL EQUIPMENT (DME) 36
4.9.1 Medical Supplies (including Diabetes Supplies) 37
4.9.2 Medical Appliances 37
4.9.3 Prosthetic and Orthotic Devices 38
4.9.4 Durable Medical Equipment (DME) 38
4.10 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES 38
4.10.1 Mental Health Services 38
4.10.2 Applied Behavior Analysis 38
4.10.3 Substance Abuse Services 39
4.11 HOME HEALTH CARE AND HOSPICE CARE 40
4.11.1 Home Health Care 40
4.11.2 Hospice Care 40
4.12 OTHER COVERED SERVICES 41
4.12.1 Genetic Testing and Counseling Services 41
4.12.2 Inborn Errors of Metabolism 41
4.12.3 Podiatry/Foot Services 41
4.12.4 Reconstructive Surgery 42
4.12.5 Reconstructive Breast Surgery 42
4.12.6 Restoration of Head/Facial Structures; Limited Dental Services 42
4.12.7 Temporomandibular Joint (TMJ) Services 43
4.12.8 Self-Administered Chemotherapy 43
4.12.9 Chiropractic Manipulation 44
4.12.10 Acupuncture 44
4.12.11 Massage Therapy 44
4.12.12 Gender Dysphoria 44
4.12.13 Elective Sterilization 44
4.12.14 Hearing Loss Services 44
4.12.15 Wigs 45
4.12.16 Biofeedback 46
4.13 HUMAN ORGAN/TISSUE TRANSPLANTS 46
4.13.1 Covered Services 46
4.13.2 Benefits for Transplant Facility Services Provided to the Organ Recipient 47
4.13.3 Benefits for Outpatient Medications 47
4.13.4 Benefits for Physician/Provider Services Provided to the Organ Recipient 47
4.13.5 Transplant Prior Authorization 47
4.13.6 Transplant Exclusions 48
4.14 PRESCRIPTION DRUG BENEFIT 48
4.14.1 Using Your Prescription Drug Benefit 48
4.14.2 Use of Out-of-Network Pharmacies 50
4.14.3 Prescription Drug Formulary 50
4.14.4 Prescription Drugs 51
4.14.5 Prescription Drug Quantity 51
4.14.6 Participating Mail-Order and Preferred Retail Pharmacies 51
4.14.7 Prescription Drug Limitations 52

4.14.8 Prescription Drug Exclusions 53
4.14.9 Prescription Drug Disclaimer 54
5. EXCLUSIONS 55
6. CLAIMS ADMINISTRATION 61
6.1 CLAIMS PAYMENT 61
6.1.1 Timely Submission of Claims 62
6.1.2 Right of Recovery 63
6.2 COORDINATION OF BENEFITS 63
6.2.1 Definitions Relating to Coordination of Benefits 63
6.2.2 Order of Benefit Determination Rules 65
6.2.3 Effect on the Benefits of This Plan 67
6.2.4 Right to Receive and Release Needed Information 67
6.2.5 Facility of Payment 68
6.2.6 Right of Recovery 68
6.2.7 Coordination with Medicare 68
6.3 THIRD-PARTY LIABILITY/SUBROGATION 68
6.3.1 Third-Party Liability/Subrogation and How It Affects You 69
6.3.2 Proceeds of Settlement or Recovery 70
6.3.3 Suspension of Benefits and Reimbursement 70
6.3.4 Special Rules for Motor Vehicle Accident Cases 71
7. PROBLEM RESOLUTION 72
7.1 INFORMAL PROBLEM RESOLUTION 72
7.2 MEMBER GRIEVANCE AND APPEAL 72
7.2.1 Your Grievance and Appeal Rights 73
7.2.2 Internal Grievance or Appeal 74
7.2.3 External Review 74
7.2.4 How to Submit Grievances or Appeals and Request Appeal Documents 75
8. ELIGIBILITY AND ENROLLMENT 76
8.1 EMPLOYEE ELIGIBILITY AND ENROLLMENT 76
8.1.1 Employee Eligibility Date 76
8.1.2 Employee Effective Date 76
8.1.3 Employee Enrollment 76
8.2 DEPENDENT ELIGIBILITY AND ENROLLMENT 76
8.2.1 Eligibility Date 76
8.2.2 Additional Requirements for Eligible Family Dependent Coverage 76
8.2.3 Eligible Family Dependent Enrollment 77
8.2.4 Newborn Eligibility and Enrollment 77
8.2.5 Open Enrollment Period 77
8.2.6 Changes in Eligibility 77
8.2.7 Members No Longer Eligible for Coverage 77
8.3 SPECIAL ENROLLMENT PERIODS 78
8.3.1 Loss of Other Coverage 78
8.3.2 New Dependents 79
8.3.3 Court Orders 79

8.3.4 Premium Assistance 79
8.4 LEAVE OF ABSENCE AND LAYOFFS 80
9. TERMINATION OF MEMBER COVERAGE 81
9.1 TERMINATION DATES 81
9.2 TERMINATION AND RESCISSION OF COVERAGE DUE TO FRAUD OR ABUSE 81
9.3 NON-LIABILITY AFTER TERMINATION 81
9.4 DISENROLLMENT FROM THIS PLAN 82
9.5 NOTICE OF CREDITABLE COVERAGE 82
9.6 CLACKAMAS COUNTY'S RIGHT TO TERMINATE OR AMEND PLAN 82
10. CONTINUATION OF GROUP MEDICAL BENEFITS 83
10.1 COBRA CONTINUATION COVERAGE 83
10.1.1 Subscriber's Continuation Coverage 83
10.1.2 Spouse's or Domestic Partner's Continuation Coverage 83
10.1.3 Dependent's Continuation Coverage 83
10.1.4 Notice Requirements 84
10.1.5 Type of COBRA Continuation Coverage 84
10.1.6 COBRA Election Rights 84
10.1.7 COBRA Premiums 84
10.1.8 Length of COBRA Continuation Coverage 84
10.1.9 Extension of Continuation Period 85
10.1.10 Trade Act of 2002 86
10.1.11 When COBRA Continuation Coverage Ends 86
11. MEMBER RIGHTS AND RESPONSIBILITIES 87
11.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES 87
11.2 INFORMATION FOR NON-ERISA MEMBERS (PARTICIPANTS) 88
12. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO) 90
12.1 DEFINITIONS 90
12.2 NOTICE UPON RECEIPT OF ORDER 90
12.3 NOTICE OF DETERMINATION 90
12.4 ENROLLMENT OF ALTERNATE RECIPIENT 91
12.5 COST OF COVERAGE 91
12.6 REIMBURSEMENT OF PLAN EXPENSES 91
12.7 STATUS OF ALTERNATE RECIPIENT 92
12.8 TREATMENT OF NATIONAL MEDICAL SUPPORT NOTICE 92
13. GENERAL PROVISIONS 93
13.1 CONFLICTS OF PROVISIONS 93
13.2 CONTROLLING STATE LAW 93
13.3 DUPLICATING PROVISIONS 93
13.4 FAILURE TO PROVIDE INFORMATION OR PROVIDING INCORRECT OR INCOMPLETE INFORMATION 93
13.5 GENDER AND NUMBER 93
13.6 HEADINGS 93
13.7 LEGAL ACTION 94
13.8 LIMITATIONS AND PROVISIONS 94

13.9 MEMBER RESPONSIBILITY 94
13.10 MEMBERSHIP ID CARD 94
13.11 NON-TRANSFERABILITY OF BENEFITS 94
13.12 NO GUARANTEE OF EMPLOYMENT 94
13.13 NO RECOURSE FOR ACTS OF PROVIDERS 95
13.14 NON-WAIVER 95
13.15 NOTICE 95
13.16 NOTICE REQUIRED FOR REIMBURSEMENT AND PAYMENT OF CLAIM 95
13.17 PAYMENT OF BENEFITS TO PERSONS UNDER LEGAL DISABILITY 95
13.18 PHYSICAL EXAMINATION AND AUTOPSY 96
13.19 PROFESSIONAL REVIEW AND RIGHT TO EXAMINE RECORDS 96
13.20 REQUIRED INFORMATION TO BE FURNISHED 96
13.21 RIGHT OF RECOVERY 96
13.22 SEVERABILITY 96
13.23 STATE MEDICAID BENEFITS RIGHTS 97
13.24 SUGGESTIONS 97
13.25 VETERANS' RIGHTS 97
13.26 WORKERS' COMPENSATION INSURANCE 97
14. PLAN ADMINISTRATION 98
14.1 TYPE OF ADMINISTRATION 98
14.2 PLAN INFORMATION 98
14.3 PLAN DATES 98
14.4 PLAN SPONSOR INFORMATION 98
14.5 ADMINISTRATIVE SERVICES PROVIDED BY 98
14.6 AGENT FOR SERVICE OF LEGAL PROCESS 98
14.7 ADMINISTRATIVE SERVICES 99
14.7.1 Complete Allocation of Fiduciary Responsibilities 99
14.8 ENGAGEMENT OF ADVISORS 99
14.9 INDEMNIFICATION 99
14.10 AMENDMENT OR TERMINATION OF PLAN 99
14.10.1 Right to Amend or Terminate 99
14.10.2 Manner of Action 100
14.10.3 Effect on Benefits 100
14.11 PROTECTED HEALTH INFORMATION 100
14.11.1 Disclosure 100
14.11.2 Security 101
15. DEFINITIONS 102
16. NON-DISCRIMINATION STATEMENT 115

1. INTRODUCTION

Statement from Plan Sponsor

Clackamas County has designed this Plan in cooperation with Providence Health Plan. The benefits under the Plan are provided by Clackamas County on a self-insured basis. Clackamas County 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.

Clackamas County Benefits & Wellness: 503-655-8550

Customer Service Quick Reference Guide:

Medical 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 Chemical Dependency 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)
Providence Resource Line To find a care provider or to register for Providence classes	503-574-6595
myProvidence Help Desk	503-216-6463 877-569-7768 (toll-free)
LifeBalance	503-234-1375 888-754-LIFE (toll-free) www.LifeBalanceProgram.com
Provider Directory	ProvidenceHealthPlan.com/findaprovider

1.1 KEY FEATURES OF YOUR CLACKAMAS COUNTY GENERAL COUNTY EMPLOYEES PERSONAL OPTION PLAN

- Some capitalized terms have special meanings. Please see section 15, Definitions.
- In this Summary Plan Description, Providence Health Plan and Clackamas County 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; and
- Providence Health Plan's national network of In-Network Providers.
- Covered Services must be obtained from In-Network Providers, with the following exceptions:
    - Emergency Services and Urgent Care Services, as specified in section 4.5;
    - Covered Services received by an enrolled Out-of-Area Dependent, as specified in section 3.5.2; and
    - Covered Services delivered by an Out-of-Network Provider when those Services have been approved in advance through the Prior Authorization procedures specified in section 3.7.
- 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 3.7.**
- Coverage limitations and exclusions apply to certain Services, as stated in sections 3, 4, and 5 and the Benefit Summary.
- 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 Plan documents. 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 or amendments that accompany these documents, the agreement between Providence Health Plan and the Plan Sponsor (if any), 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) Providence Health Plan/ Plan Sponsor agreement, (3) Summary Plan Description, (4) Benefit Summary(ies), and (5) 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 Clackamas County General County Employees and their Dependents.

2.1 CLACKAMAS COUNTY GENERAL COUNTY EMPLOYEES PERSONAL OPTION PLAN

Your Plan allows you to receive Covered Services from In-Network Providers.

It is your responsibility to verify whether or not a physician/provider, Hospital or other facility is participating with Providence Health Plan, 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 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 for what you owe later. 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 Clackamas County. 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 15. 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:

- **Clackamas County General County Personal Option Medical Benefit Summary** and any other Benefit Summary documents issued with this Plan. These documents are available at www.ProvidenceHealthPlan.com when you register for a myProvidence account as explained in section 2.4. Benefit Summaries detail your Deductible, 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 or check with your Employer's human resource department 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.

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. 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. If you have questions or need assistance registering for or accessing an existing account, contact myProvidence customer service at 877-569-7768

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 confer 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:

- Visit your health care provider or facility.
- Register online for your myProvidence account.
- Call for Mental Health/Substance Abuse 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 recorded message, a registered nurse will come on line to assist you.

Please have your Member ID Card available when you call.

2.7 WELLNESS BENEFITS

Providence Resource Line — 503-574-6595; 800-562-8964

Providence Resource Line is your connection to information and services on classes, self-help materials, tobacco-use cessation services, and for referrals to Providence Health Plan In-Network Providers and to Providence Health & Services programs and services. Services and health-education vary by geographic service area.

Health Education

Providence Health Plan offers a wide variety of classes to help you achieve healthy lifestyle and wellness goals. We can assist you in learning to eat right and manage your weight, prepare for childbirth and much more. If you have diabetes, health education classes also are available (see section 4.1.6 for further information).

Providence Health Plan Members receive discounts on health education classes. Your costs, services and the health education classes available may vary by geographic-service area. For more information on classes available in your area, call the Providence Resource Line at 503-574-6595 or 800-562-8964 or visit www.providence.org/classes.

Health Coaching

Providence Health Plan offers Members free coaching support for weight loss, diabetes prevention, nutrition, stress management, exercise, sleep and tobacco cessation. For more information on health coaching, call 503-574-6000 (TTY: 711) or 888-819-8999 or visit www.ProvidenceHealthPlan.com/healthcoach.

Care Management
Providence Care Management provides Members with information and assistance with healthcare navigation, as well as managing chronic conditions from a Registered Nurse Care Manager.

You can access these Services by calling 800-662-1121 or e-mailing caremanagement@providence.org.

Tobacco Use Cessation
Your Wellness Benefits include access to tobacco-use cessation programs provided through our Providence Health & Services Hospitals as well as through Quit for Life. These programs address tobacco dependence through a clinically proven, comprehensive approach to tobacco-use cessation that treats all three aspects of tobacco use – physical addiction, psychological dependence and behavioral patterns. (See section 4.1.8 regarding coverage for tobacco-use cessation Services).

More information about our Tobacco-Use Cessation programs can be found online at http://www.providence.org/healthplans/members/healthbalance/smokingcessation.aspx, or by calling 503-574-6595 or 800-562-8964.

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

Wellness information on our website — www.ProvidenceHealthPlan.com
Visit Providence Health Plan online at www.ProvidenceHealthPlan.com for medical information, class information, information on extra values and discounts and a wide array of other information described with your good health in mind. You also may set up your own myProvidence account to gain access to your specific personal health plan information. See *Registering for a myProvidence account*, section 2.4 for more details.

LifeBalance — 503-234-1375 or 888-754-LIFE www.LifeBalanceProgram.com
This program offers exclusive discounts to Providence Health Plan Members on a wide variety of health and wellness programs, as well as recreational, cultural and wellness activities. You can save on professional instruction, fitness club memberships, yoga classes, and much more. You also have access to discounted events, such as white-water rafting, ski trips, theater nights, and sporting events.

Learn more by visiting the LifeBalance website at www.LifeBalanceProgram.com or calling LifeBalance at 503-234-1375 or 888-754-LIFE. Please have your Providence Health Plan Member ID Card ready when you request LifeBalance discounts.

Assist America
Your wellness benefits include access to travel assistance services and identity theft protection services.

Travel Assistance Services include emergency logistical support to members traveling internationally or people traveling 100 miles from home. Learn more by visiting www.assistamerica.com or calling Assist America at 609-986-1234 or 800-872-1414.

Assist America also provides identity theft protection services 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. Please have your Providence Health Plan Member ID card ready, 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 https://healthplans.providence.org/members/rights-notices or by calling Customer Service.

Appointment of Authorized Representative

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

Confidentiality and your Employer

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

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

1. In compliance with the applicable provisions of HIPAA; and
2. Due to a HIPAA compliant authorization, the Member has completed to allow the Employer access to the Member's PHI; or
3. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer. The details of this required certification can be reviewed at https://healthplans.providence.org/about-us/privacy-notices-policies/protected-health-information-and-your-employer/.

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. HOW TO USE YOUR PLAN

Our goal is maintaining your health by promoting wellness and preventive care. We encourage you to work closely with one provider, your 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 section 4 of this Summary Plan Description.

3.1 IN-NETWORK PROVIDERS

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

For Services to be covered, 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.

3.1.1 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 of Oregon and southwest Washington.

3.1.2 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 the Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider. If you do not have access to our website, please call Customer Service to request an In-Network Provider Information.

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 3.7.

3.1.3 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 St., Ste. 800
Portland, OR 97209
Telephone: 503-414-5555

3.2 THE ROLE OF A PRIMARY CARE PROVIDER

To encourage optimum health, we promote wellness and preventive care. We also believe wellness and overall health is enhanced by working closely with one physician or provider – your 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 an In-Network Primary Care Provider as soon as possible.

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

3.2.2 Established Patients with Primary Care Providers

If you and your family already see a provider, you may want to check the provider directory to see if your provider is an In-Network Primary Care Provider for Providence Health Plan. If your provider is participating with us, let their office know you are now a Providence Health Plan Member.

3.2.3 Selecting a New Primary Care Provider

We recommend 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 they are 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.

3.2.4 Changing Your Primary Care Provider

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.

3.2.5 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 your treatment.

You also may decide to see a specialist without consulting your Primary Care Provider. Visit the Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider, or call Customer Service to choose a specialist who 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. (For certain Plans, there is a Member Copayment for specialist visits instead of a Coinsurance. If you are on one of these Plans, you will need to pay your Member Copayment at the time of your visit. Please check your Benefit Summary for your specific coverage information.)

Alternative Care Providers

This Plan includes coverage for office visits to alternative care providers, as listed in your Benefit Summary. See section 15 for the definition of Alternative Care Provider. For coverage of chiropractic manipulation and acupuncture, see sections 4.12.9, 4.12.10 and your Benefit Summary.

3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS

Providence Health Plan may approve and provide reimbursement for Out-of-Network Qualified Practitioners and facilities. Benefits for Covered Services by an Out-of-Network provider will be provided as shown in the Benefit Summary when we determine **in advance**, in writing, that the Out-of-Network Provider possesses unique skills which are required to adequately care for you and are not available from In-Network Providers.

Under no circumstances (with the exception of Emergency and Urgent Care) will we cover Services received from an Out-of-Network Provider/Facility *unl*ess we have Prior Authorized the Out-of-Network Provider/Facility and the Services received.

IMPORTANT NOTE: Your Plan only pays for Covered Services received from Prior Authorized Out-of-Network Providers at Usual, Customary, and Reasonable rates (UCR) (see Section 15, Definitions). If the approved, Prior Authorized Out-of-Network Provider charges more than the UCR rates allowed under your Plan, that provider may bill you directly for the additional amount that is not covered by your Plan. That amount is in addition to any Deductible, Copayment, or Coinsurance for which you may be responsible, and does not accrue to your Out-of-Pocket Maximum.

If you choose to receive Covered Services from an approved, Prior Authorized Out-of-Network Provider, those Services are still subject to the terms of this Summary Plan Description. Your 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.

It is important for you to understand that Providence Health Plan has not assessed the approved, Prior Authorized Out-of-Network 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.

Payment for Out-of-Network Physician/Provider Services (UCR)
After you meet your Deductible, if applicable, and if the Services provided are Medically Necessary Covered Services, we will provide payment to Out-of-Network Providers according to Usual, Customary and Reasonable (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 15 for the definition of UCR.

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

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

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

Payment for 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.

3.4 MOVING INTO OR OUT OF THE SERVICE AREA

If you or a Family Member permanently moves into or out of the Service Area, you must immediately notify us and your Employer as such a move may affect your benefits or coverage under this Personal Option Plan. We will determine how this move affects your coverage and will inform you of any changes. If you have Dependent(s) who move in or out of our Service Area, a Change of Status form for those Dependent(s) must be completed and returned to us as soon as possible. This form can be obtained from us or from your Employer. See section 8.3.1 for more information.

3.5 OUT-OF-AREA DEPENDENTS

Dependents of a subscriber on a Personal Option Plan who live outside the Providence Health Plan Service Area (including dependents who are away at school) are eligible to become Out-of-Area Dependent Members. *See "Definitions" section 15, for the definition of "Eligible Family Dependent" and "Out-of-Area Dependent."* This section discusses how Enrolled Out-of-Area Dependent Personal Option Plan Members obtain covered services through Providence Health Plan's enrolled Out-of-Area Dependent benefit.

3.5.1 Out-of-Area Dependent Enrollment

To apply for Personal Option Out-of-Area Dependent benefits, complete an Out-of-Area Dependent Enrollment form, available from your Customer Service team. **If you do not complete an Out-of-Area Dependent Enrollment form, your Out-of-Area Dependent will not be covered for Out-of-Area Dependent benefits.**

3.5.2 Out-of-Area Dependent Coverage

When you enroll for Out-of-Area Dependent coverage, we will send you an Out-of-Area Dependent Benefit Summary. As stated in your Benefit Summary, a Dependent with Out-of-Area benefits may see any provider, in or out of the Service Area. Please refer to your Out-of-Area Dependent Benefit Summary for detailed Coinsurance or Copayment and annual Out-of-Pocket Maximum information. (For Out-of-Area Dependents who are covered by a government sponsored health plan of a county other than the United States, coverage under this Personal Option Out-of-Area Dependent plan will be secondary and will not replace or duplicate coverage available under the government sponsored plan.) Our payment is based on usual, customary and reasonable (UCR) charges. Charges which exceed UCR charges are your responsibility.

You must purchase your prescription drugs at one of our nationwide Participating Pharmacies (see section 4.14.1**.** A list of our Participating Pharmacies is available online at www.ProvidenceHealthPlan.com. You also may contact Customer Service if you need help locating a Participating Pharmacy near you or when you are away from your home. See your Benefit Summary for details on your Copayment and Coinsurance, if applicable, and on how to use this benefit.

3.5.3 Out-of-Area Dependents and Change of Status

Enrolled Out-of-Area Dependents may change to In-Area or Out-of-Area status by contacting us and completing a status change enrollment form. The change will be effective the date you specify or if no date is specified, on the first of the month following our receipt of the enrollment form. Retroactive changes are limited to 30 days.

3.5.4 Out-of-Area Dependents Prior Authorization

Enrolled Out-of-Area Dependents are responsible for obtaining Prior Authorization from Providence Health Plan prior to receiving certain services from Out-of-Network Providers. For further information about Prior Authorization, including a list of these Covered Services and how to obtain Prior Authorization, see section 3.7.

You must contact us to obtain Prior Authorization for specified Covered Services if the Services are to be received from an Out-of-Network Provider. See section 3.7.

3.6 NOTICE OF PROVIDER TERMINATION

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

3.7 PRIOR AUTHORIZATION

While Prior Authorization is a requirement for coverage of certain Services under this Plan, Prior Authorization is not a treatment directive. The actual course of medical treatment that a Member chooses remains strictly a matter between the Member and the 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 Medical Necessity.

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. You or your Out-of-Network Provider must contact us to obtain Prior Authorization. See section 3.3 for additional information about Out-of-Network Providers.

Services requiring Prior Authorization:

- All inpatient admissions to a Hospital (not including emergency room care), Skilled Nursing Facility or a rehabilitation facility, all emergency hospitalizations (we need to be notified within 48 hours, or as soon as reasonably possible), and all Hospital and birthing center admissions for maternity/delivery Services.
- All outpatient surgical procedures.
- Anesthesia Care with Diagnostic Endoscopy.
- All Travel Expense Reimbursement, as provided in section 3.8.
- All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services for Mental Health and Substance Abuse, as provided in sections 4.10.1 and 4.10.3.
- All Applied Behavior Analysis, as provided in section 4.10.2.
- All Human Organ/Tissue Transplant Services, as provided in section 4.13.
- All Restoration of Head/Facial Structures; Limited Dental Services, as provided in section 4.12.6.
- All Temporomandibular Joint (TMJ) Services, as provided in section 4.12.7.
- All High Tech Imaging, including PET, CT, CTA, MRI and MRA, Nuclear Cardiac Study Services, and echocardiography Services, as provided in section 4.4.1.
- All Sleep Study Services, as provided in section 4.4.2.
- Certain Home Health Care Services, as provided in section 4. 11.1.
- Certain Hospice Care Services, as provided in section 4.11.2.
- Certain Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment, as provided in section 4.9.
- Certain outpatient services including, but not limited to, neurodevelopmental therapy, neurological testing, and botulinum therapies.
- All outpatient hospitalization and anesthesia for dental Services, as provided in section 4.12.6.
- All Genetic Testing Services, as provided in section 4.12.1.

- Certain medications, including certain immunizations, received in your Provider's office, as provided is sections 4.3.5 and 4.1.2.
- Certain prescription drugs specified in our Formulary, as provided in section 4.14.1.
- Certain infused Prescription Drugs administered in a hospital-based infusion center, as provided in section 4.7.1.

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 section 3.3, a 50% **penalty,** not to exceed $2,500 for each Covered Service, will be applied to the claim.

Should Providence Health Plan 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.

3.8 TRAVEL EXPENSE REIMBURSEMENT

Subject to Prior Authorization, if you are unable to locate an In-Network Provider to provide Medically Necessary Covered Services for your specific condition within 50 miles of your home, the Plan will reimburse your travel expense to the nearest In-Network Provider within 300 miles of your home. Reimbursement will be based on the federal medical mileage reimbursement rate in effect on the date of service. Travel expense reimbursement is limited to $1,500 per calendar year. If an overnight stay is required, food and lodging are reimbursable up to $150 per diem (per day). Per diem expenses apply to the $1,500 travel expenses reimbursement maximum. (Note: Transplant Covered Services include a separate travel expense benefit; see section 4.13.1).

3.9 MEDICAL COST MANAGEMENT

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

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 Services 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.

3.9.1 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 7.

3.10 MEDICALLY NECESSARY SERVICES

We believe our Members are entitled to comprehensive medical care within the standards of good medical practice. Providence Health Plan's medical directors and special committees of In-Network Providers determine which Services are Medically Necessary, as defined in section 15. 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 our guidelines. Obtaining confirmation of coverage from Providence Health Plan beforehand is always recommended.

3.11 APPROVED CLINICAL TRIALS

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

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

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

The following costs are excluded:

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

The 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.

3.12 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.

3.13 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.

3.13.1 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 us. Deductible amounts are payable to your Qualified Practitioner after we have processed your claim.

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

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

Family Deductible: The Family Deductible is the amount shown in the Benefit Summary that applies when two or more 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.

3.13.2 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.

Individual Out-of-Pocket Maximum: Individual Out-of-Pocket Maximum means the total amount of Copayments, Coinsurance and Deductible that a Member must pay in a Calendar Year, as shown in the Benefit Summary, before the Plan begins to pay 100% for Covered Services for that Member within that Calendar Year.

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

Note: Once any 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 by this Plan;
- Services not covered because Prior Authorization was not obtained, as required in section 3.7;
- 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; and
- Any penalties you must pay if you do not follow 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. COVERED SERVICES

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

Please refer to your Benefit Summary for details of your specific coverage. You can view your Member materials by registering for a myProvidence account on our website at www.ProvidenceHealthPlan.com (see section 2.4). If Clackamas County modifies your benefits, you will be notified in writing of the changes.

You must use In-Network Providers to receive the Covered Services listed in this section, unless you are an Enrolled Out-of-Area Dependent or have received Prior Authorization to receive services from an Out-of-Network Provider.

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

4.1 PREVENTIVE SERVICES

Preventive Services are covered as shown in the Benefit Summary. For Women's Preventive Health Care Services, see section4.2.
In accordance with the Patient Protection and Affordable Care Act of 2010 and related legislation, your Plan covers the following Services in full when received from In-Network Providers:

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

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

4.1.1 Physical Examinations and Well-Baby Care

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

enrolled as outlined in section 8. Ancillary Services, such as immunizations, are covered at the specified benefit level when billed by the provider.

Recommended Guidelines:

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. The Plan will not cover this additional fee.

Covered Services do **NOT** include the following:

1. Services for laser surgery, radial keratotomy and any other surgery to correct myopia, hyperopia or stigmatic error, vision therapy, orthoptic treatment (eye exercises);
2. Services for routine eye and vision care, refractive disorders, eyeglass frames and lenses, contact lenses; and
3. Hearing aids, including all Services related to the examination and fitting of hearing aids; except as specified in section 4.12.14.

4.1.2 Immunizations and Vaccinations

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

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

4.1.3 Prostate Cancer Screening Exams

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

4.1.4 Colorectal Cancer Screening Exams

Benefits for colorectal cancer screening examinations 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.

All colonoscopy and sigmoidoscopy Services are covered in full, including prescription drug bowel prep kits as listed in our Formulary.

4.1.5 Preventive Services for Members with Diabetes

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

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

4.1.6 Diabetes Self-Management Education Program

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

4.1.7 Nutritional Counseling

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

4.1.8 Tobacco Use Cessation Services

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

4.2 WOMEN’S PREVENTIVE HEALTH CARE SERVICES

Women may choose to receive Women’s Preventive Health Care Services from a Primary Care Provider or a Women’s Health Care Provider. 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.

4.2.1 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 4.2.4). Benefits also include follow-up exams for any medical conditions discovered during an Annual gynecological exam that require additional treatment.

4.2.2 Mammograms

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

4.2.3 Breastfeeding Counseling and Support

Coverage for lactation counseling is provided when Medically Necessary as determined by the Qualified Practitioner. Lactation Counseling Services must be received from licensed providers. Benefits include coverage in full for breast pump equipment and supplies when rented or purchased through In-Network Medical Equipment Providers.

4.2.4 Family Planning Services

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

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

- Intrauterine device (IUD) insertion and removal;
- Medical exams and consultation for family planning;
- Depo-Provera to prevent pregnancy;
- Diaphragm devices;
- Removal of implantable contraceptives; and
- Oral contraceptives (birth control pills) listed in our Formulary. FDA-approved women's prescription contraceptives: up to 3 months initial dispensing, then up to 12 months subsequent dispensing at any Network Pharmacy.

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

For coverage of tubal ligation, see Elective Sterilization, section 4.12.13.

4.3 PROVIDER SERVICES

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

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

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

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

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

4.3.2 Virtual Visits

The Plan provides coverage for Virtual Visits with In-Network Providers using secure internet technology:

- Phone and Video Visits: Phone and Video Visits are covered as shown in your Benefit Summary. All Phone and Video Visits must be Medically Necessary and received from In-Network Providers. Not all In-Network Providers are contracted with us to provide Phone and Video Visits. In-Network Providers who are authorized to provide Phone and Video Visits have agreed to use secure internet technology approved by us to protect your information from unauthorized access or release.
- Web-direct Visits: Web-direct Visits for common conditions such as cold, flu, sore throat, allergy, ear ache, sinus pain, or UTI are covered as shown in your Benefit Summary. The Member completes a questionnaire to describe the common condition. The questionnaire is reviewed by an In-Network Provider who makes a diagnosis and sends a treatment plan back to the Member. If needed, a prescription is sent to the Member's pharmacy. All Web-direct Visits must be Medically Necessary and received from authorized In-Network Providers.

4.3.3 E-mail Visits

E-mail Visits are covered in full and must be received from In-Network Providers. Not all In-Network Providers offer E-mail Visits. Medical doctors (M.D.), doctors of osteopathy (D.O.), nurse practitioners (N.P.) and physician assistants (P.A.) are the only categories of providers 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 the Plan;
- 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 Abuse Covered Services (as provided in section 4.10).

4.3.4 Telemedical Services

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

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

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

4.3.5 Allergy Shots, Allergy Serums, Injectable and Infused Medications

Allergy shots, allergy serum, injectable medications, and total parenteral nutrition (TPN) received in your Provider's office are covered as shown in your Benefit Summary. Therapy and testing for treatment of allergies including, but not limited to, Services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment are covered only when such therapy or testing is approved by the American Academy of Allergy and Immunology, or the Department of Health and Human Services or any of its offices or agencies. Some injectable medications may require Prior Authorization, as listed in the Medical benefit drug prior authorization list available on our website at https://healthplans.providence.org/members/pharmacy-resources/Pages/default.aspx or by calling Customer Service. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. See section 4.7.1 for coverage of infusion at Outpatient Facilities.

4.3.6 Administration of Anesthesia and Surgical Procedures

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

4.3.7 Immediate Care

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

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

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

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

4.4 DIAGNOSTIC SERVICES

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

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

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

4.4.2 Sleep Study Services

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

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

4.5 EMERGENCY CARE AND URGENT CARE SERVICES

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

4.5.1 Emergency Care

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

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

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

Definitions:
"Emergency Medical Condition" is a medical condition that manifests itself by acute symptoms of sufficient severity that a prudent layperson, possessing an average knowledge of health and medicine, would reasonably expect that failure to receive immediate medical 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 any 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:

- An Emergency Medical Screening Exam or behavioral health assessment that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
- Such further medical examination and treatment as are required under the Emergency Medical Treatment and Active Labor Act (42 U.S.C. 1395dd) to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at the Hospital.

"Emergency Medical Screening Exams" include medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.

Your Plan covers Emergency Services in the emergency room of any Hospital. **Emergency room Services are covered when your medical condition meets the guidelines for emergency care as stated above. Coverage includes Services to stabilize an Emergency Medical Condition and Emergency Medical Screening Exams.**

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

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

Please be prepared to pay your Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are responsible for the Copayment/Coinsurance for each Hospital emergency room visit. If you are admitted to the Hospital from the emergency room, your emergency Services Copayment/Coinsurance does not apply and all Services are subject to the Inpatient Services benefit shown in your Benefit Summary.

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

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

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

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

4.5.2 Emergency Medical Transportation

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

4.5.3 Emergency Eye Care Services

Covered Services include the initial care for Emergency Medical Conditions 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.

4.5.4 Emergency Detoxification Services

Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a Substance Abuse treatment program, as stated in section 4.10.3, 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. Continuing or follow-up care is not a Covered Service unless Prior Authorized by Providence Health Plan.

4.5.5 Urgent Care

Urgent Care is treatment you need right away for an illness or injury that is not life threatening. This includes, but is not limited to, minor sprains, minor cuts and burns, and ear, nose, and throat infections. Routine care that can be delayed until you can be seen by a physician or provider in their 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. They may either suggest that you come to the office or go to an emergency room or Urgent Care center. If you can be treated in your provider's office or at an In-Network Urgent Care center your out-of-pocket expense will usually be lower.

Please be prepared to pay the Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are also responsible for the applicable

Copayment/Coinsurance shown in the Benefit Summary for any ancillary Services received, such as lab tests and X-rays, billed by the Qualified Provider.

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

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

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

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

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

4.6 INPATIENT HOSPITAL AND SKILLED NURSING FACILITY SERVICES

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

- Covered Services do NOT include care received that consists primarily of:
- Room and board and supervisory or custodial Services.
- Personal hygiene and other forms of self-care.
- Non-skilled care for senile deterioration, mental deficiency, or developmental disability.

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

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

4.6.1 Inpatient Hospital Services

Benefits are provided as shown in your Benefit Summary.

When your In-Network Provider and Providence Health Plan determine you need hospitalization, arrangements will be made for you to be admitted to an In-Network Hospital.

For Enrolled Out-of-Area Dependents: 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; and
- Hospital services and supplies necessary for treatment and furnished by the Hospital, such as use of the operating and recovery rooms, anesthesia, dressings, medications, whole blood and blood products, oxygen, X-ray, and laboratory Services during the period of inpatient hospitalization. (Personal items such as guest meals, slippers, etc., are not covered.)

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

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

4.6.2 Skilled Nursing Facility

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

4.6.3 Inpatient Rehabilitative Care

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

4.6.4 Inpatient Habilitative Care

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

4.6.5 Observation Care

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

4.7 OUTPATIENT SERVICES

4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy

Benefits are provided as shown in the Benefit Summary and include Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, and therapeutic procedures as ordered by your Qualified Practitioner. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. The Plan may require that you obtain a second opinion for some 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 3.7.

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

4.7.2 Outpatient Rehabilitative Services

Benefits are included for outpatient physical, occupational and speech therapy Covered Services provided by a physician or licensed/registered therapist, as stated in the Benefit Summary, to restore or improve lost function following illness or injury.

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). All Services are subject to review for Medical Necessity. Limits do not apply to Mental Health Covered Services. (See section 4.6.3 for coverage of Inpatient Rehabilitative Services.)

Covered Services under this benefit do NOT include:

- Chiropractic adjustments and manipulations of any spinal or bodily area;
- Exercise programs;
- Rolfing, polarity therapy and similar therapies; and
- Rehabilitation services provided under an authorized home health care plan as stated in section 4. 11.

4.7.3 Outpatient Habilitative Services

Coverage is provided, as shown in the Benefit Summary, for Medically Necessary outpatient habilitative Services. All Services are subject to review for Medical Necessity and must be received at Qualified Facilities and from Qualified Practitioners practicing within their scope of license. Services are limited to those that result in measurable development. Coverage is provided at the same benefit level as Outpatient Rehabilitative Care listed in your Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 4.6.4 for coverage of Inpatient Habilitative Services.)

4.8 MATERNITY SERVICES

Your benefits include coverage for comprehensive maternity care.

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

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

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**.

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

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

PLEASE NOTE: Newborn nursery care, newborn nurse home visits, and any other Services provided to your newborn are covered only when the newborn child is properly enrolled under this Plan within time frames outlined in Newborn Eligibility and Enrollment, section 8.2.4.

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

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

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

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

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

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

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

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

4.9.1 Medical Supplies (including Diabetes Supplies)

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

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

4.9.2 Medical Appliances

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

4. 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.
5. 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.
6. 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.
7. 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.
8. 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.
9. Other Medically Necessary appliances, including Hearing Aids and Hearing Assistance Technology (HAT), as ordered by your Qualified Practitioner.

4.9.3 Prosthetic and Orthotic Devices

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

4.9.4 Durable Medical Equipment (DME)

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

4.10 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

This Plan complies with Oregon and Federal Mental Health Parity.

4.10.1 Mental Health Services

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

Covered Services include diagnostic evaluation, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services. All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services must be Prior Authorized as specified in section 3.7.

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

4.10.2 Applied Behavior Analysis

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

- Services must be Medically Necessary;
- The initial screening and an individualized treatment plan must be provided by a licensed neurologist, pediatric neurologist, developmental pediatrician, psychiatrist or psychologist, who has experience or training the diagnosis of autism spectrum disorder;
- Prior authorization is received by us;

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

Exclusions to ABA Services:

- Services provided by a family or household member;
- Services that are custodial in nature, or that constitute marital, family, or training services;
- Services that are educational or correctional that are provided by a school or halfway house or received as part of an 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.

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

4.10.3 Substance Abuse Services

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

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

Prior Authorization is required for all inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services, as specified in section 3.7.

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

In an emergency situation, go directly to a Hospital emergency room. You do not need Prior Authorization for emergency treatment; however, 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.

4.11 HOME HEALTH CARE AND HOSPICE CARE

4.11.1 Home Health Care

Benefits for home health care Covered Services are shown in the Benefit Summary and 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.

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

Home health care will not be reimbursed unless your Qualified Practitioner certifies that the home health care Services will be provided or coordinated by a state-licensed or Medicare-certified Home Health 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;
3. Charges for supervision of Home Health Providers; or
4. Services that consist principally of Custodial Care including, but not limited to, care for senile deterioration, mental deficiency, mental illness, developmental disability or care of a chronic or congenital condition on a long-term basis.

4.11.2 Hospice Care

Benefits are included for hospice care as shown in the Benefit Summary and as stated in this section. In addition, the following criteria must be met:

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

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

- Nursing care provided by or under the supervision of a registered nurse;

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

Respite care is not covered.

4.12 OTHER COVERED SERVICES

4.12.1 Genetic Testing and Counseling Services

Genetic testing and counseling are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature. Genetic testing requires Prior Authorization as shown in section 3.7.

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

4.12.2 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 4.9.1.

4.12.3 Podiatry/Foot Services

Benefits include Covered Services of a podiatrist or other Qualified Practitioner and are provided as shown in the Physician/Provider Services section of the Benefit Summary. Covered Services include, but are not limited to, the fitting and follow up exam for removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are covered as stated in section 4.9.2 (Medical Appliances). Covered Services do not include routine foot care and the removal of corns or calluses, unless you have diabetes.

4.12.4 Reconstructive Surgery

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

4.12.5 Reconstructive Breast Surgery

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

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

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

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

4.12.6 Restoration of Head/Facial Structures; Limited Dental Services

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

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

Exclusions that apply to Covered Services include:

- Cosmetic Services;
- Services rendered to improve a condition that falls within the normal range of such conditions;
- Routine Orthodontia;
- Services to treat tooth decay, periodontal conditions and deficiencies in dental hygiene;
- Removal of impacted teeth;

- The making or repairing of dentures;
- Orthognathic surgery to treat developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth; and
- Services to treat temporomandibular joint syndrome, including orthognathic surgery, except as provided in 4.12.7.

Outpatient Hospitalization and Anesthesia for Limited Dental Services

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

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

Dental Services are excluded.

4.12.7 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 4.9.2(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.

Covered Services for TMJ conditions do not include dental or orthodontia Services.

4.12.8 Self-Administered Chemotherapy

Self-administered chemotherapy agents, including oral medications and injectable medications, are covered when received from a Participating retail or specialty Pharmacy.

Self-administered chemotherapy is covered under your Outpatient Chemotherapy benefit. Self-administered chemotherapy is covered under your Prescription Drug benefit when that coverage results in a lower out-of-pocket expense to the Member (See section 4.14).

4.12.9 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.

4.12.10 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.

4.12.11 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.

4.12.12 Gender Dysphoria

Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.7 for a list of services requiring Prior Authorization.

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

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

4.12.14 Hearing Loss Services

Definitions:

Cochlear Implant

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

Hearing Aid

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

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

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

Cochlear implants:

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

Hearing aids & related accessories:

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

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.

Hearing Assistance Technology:

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

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

4.12.15 Wigs

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

4.12.16 Biofeedback

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

4.13 HUMAN ORGAN/TISSUE TRANSPLANTS

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

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

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

4.13.1 Covered Services

1. Covered Services for transplants are limited to Services that:
2. Are determined by Providence Health Plan to be Medically Necessary and medically appropriate according to national standards of care;
3. Are provided at a facility approved by us or under contract with Providence Health Plan;
4. 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
5. 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 lifetime benefit maximum for transportation, food and lodging. Food and lodging is subject to a $150 per diem. Per diem expenses apply to the $5,000 travel expenses lifetime 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.

4.13.2 Benefits for Transplant Facility Services Provided to the Organ Recipient

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

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

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

4.13.3 Benefits for Outpatient Medications

Outpatient prescription medications for transplant-related Services, including anti-rejection (immunosuppressive) drugs, are not eligible for reimbursement under the medical benefits of this Plan. Benefits for outpatient prescription drugs are provided under this Plan's Prescription Drug Benefit and those benefits are subject to the terms and limitations of that Benefit.

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

Benefits for physician/provider Services are provided as shown in the Benefit Summary. The Member/recipient is responsible for the 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.

4.13.5 Transplant Prior Authorization

(See also section 3.7.)

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.

4.13.6 Transplant Exclusions

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

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

4.14 PRESCRIPTION DRUG BENEFIT

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

Prescription Drug Definition

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 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.

4.14.1 Using Your Prescription Drug Benefit

Your Prescription Drug Benefit requires that you fill your prescriptions at a Participating Pharmacy.

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

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

Participating Pharmacies are designated as retail, preferred retail, specialty and mail-order Pharmacies. To view a list of Participating Pharmacies, visit our website at

www.ProvidenceHealthPlan.com. You also may contact Customer Service at the telephone number listed on your Member ID Card.

- Please present your Member ID Card to the Participating Pharmacy at the time you request Services. If you have misplaced or do not have your Member ID Card with you, please ask your pharmacist to call us.
- All covered Services are subject to the Copayments or Coinsurance listed in your Benefit Summary.
- If you choose a brand-name drug when a generic-equivalent is available, any difference in cost for Prescription Drug Covered Services will not apply to your Calendar Year Deductibles and Out-of-Pocket Maximums.
- The amount paid by a manufacturer discount and/or copay assistance programs for a brand-name drug when a generic equivalent is available may not apply towards 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 Benefit or need assistance processing your prescription.
- Copayments or Coinsurance are due at the time of purchase. If the cost of your Prescription Drug is less than your Copayment, you will only be charged the cost of the Prescription Drug.
- You may be assessed multiple Copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- You may purchase up to a 90-day supply of each maintenance 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 www.ProvidenceHealthPlan.com. (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 your Medical Supplies benefits, limitations and Copayments and/or Coinsurances. See section 4.7.1 and your Benefit Summary. Diabetes supplies do not include insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.7.4.
- Self-administered chemotherapy drugs are covered under section 4.8.14 unless the benefits under this Prescription Drug Benefit allow for a lower out-of-pocket cost to you.
- Injectable medications received in your Provider's office are covered under section 4.1.4.
- Infusions, including infused medications, received at Outpatient Facilities are covered under section 4.7.1
- Some prescription drugs require Prior Authorization or an exception to the Formulary in order to be covered. These may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in the Providence Health Plan

Prescription Drug Formulary available on our website at www.ProvidenceHealthPlan.com 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.

4.14.2 Use of Out-of-Network Pharmacies

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

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

If your claim is approved, the Plan will reimburse you the cost of your prescription up to our Participating Pharmacy contracted rates, less your Copayment or Coinsurance if applicable. 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.

4.14.3 Prescription Drug Formulary

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

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

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

Newly approved FDA drugs will be reviewed by the Oregon Region Pharmacy and Therapeutics Committee for safety and Medical Necessity within 12 months after the drug becomes available on the market. In the case of an urgent situation, Providence Health Plan

will authorize the use of a newly approved FDA drug during our review period so a Member does not go without Medically Necessary treatment.

To access the Formulary for your Plan, visit https://healthplans.providence.rg/members/pharmacy-resources/.

4.14.4 Prescription Drugs

Generic and Brand-Name Prescription Drugs

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

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

Affordable Care Act Preventive Drugs

Affordable Care Act (ACA) preventive drugs are medications, including contraceptives, which are listed in our Formulary and are covered at no cost when received from Participating Pharmacies as required by the ACA. 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.

4.14.5 Prescription Drug Quantity

Prescription dispensing limits, including refills, are as follows:

1. Topicals, up to 60 grams;
2. Liquids, up to eight ounces;
3. Tablets or capsules, up to 100 dosage units;
4. Multi-use or unit-of-use, up to one container or package; as prescribed, not to exceed a 30-consecutive-day supply, whichever is less;
5. FDA-approved women's prescription contraceptives: up to 3-months initial dispensing, then up to 12-months subsequent dispensing at any 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 our Oregon Region Pharmacy and Therapeutics Committee. Prior Authorization is required for amounts exceeding any applicable medication dispensing limits.

4.14.6 Participating Mail-Order and Preferred Retail Pharmacies

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

mail-order or preferred retail Pharmacy will be covered subject to the following specific provisions:

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

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

4.14.7 Prescription Drug Limitations

Prescription drug limitations are as follows:

1. All drugs must be Food and Drug Administration (FDA) approved, Medically Necessary and require by law a prescription to dispense. Not all FDA-approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety and Medical Necessity within 12 months after the drug becomes available on the market for Formulary consideration.
2. Certain drugs require Prior Authorization for Medical Necessity, place of therapy, length of therapy, step therapy, number of doses or dispensing limits. Step therapy uses our pharmacy claims history to confirm if certain drugs have been tried first by a Member. If a drug has not been tried first, cannot be tried first, or if the drug history is not available, Prior Authorization is required. For some drugs, Providence Health Plan limit the amount of the drug the Plan will cover. You or your Qualified Practitioner can contact Providence Health Plan directly to request Prior Authorization. If you have questions regarding a specific drug, please call Customer Service.
3. Specialty drugs are injectable, infused, oral, topical, or inhaled therapies that often require specialized delivery, handling, monitoring and administration and are generally high cost. These drugs must be purchased through a Providence Health Plan designated specialty pharmacy. Due to the nature of these medications, specialty drugs are limited to a 30-day supply. Specialty drugs are listed in the Formulary. In rare circumstances specialty medications may be filled for greater than a 30-day supply; in these cases, additional specialty cost share(s) may apply.
4. Self-injectable medications are only covered when they are being self-administered and labeled by the FDA for self-administration; in some cases, a Prior Authorization may be required for the drug. Documentation of self-administration may also be required. Drugs labeled for self-administration that are being administered by a provider will fall to the Member's medical benefit.
5. Medications, drugs or hormones prescribed to stimulate growth are not covered, except when there is a laboratory-confirmed diagnosis of growth hormone deficiency for children through 18 years of age and when prescribed for the treatment of documented pituitary destruction in adults.
6. 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.

7. In accordance with the ACA, your Plan provides coverage in full of certain medications, including contraceptives, when these medications are purchased from Participating Pharmacies. Not all preventive medications are required to be covered in full by the ACA. Medications in this category may be subject to medical management techniques to determine frequency, method, treatment, or setting. Brand medications for which a generic is available will not be covered in full unless the Member has received Prior Authorization from Providence Health Plan.
8. Vacation supply medication refill overrides are limited to a 30-day supply once per Calendar Year, unless otherwise provided under your Plan. Additional exceptions may be granted on a case-by-case basis.
9. A 30 day supply medication refill override will be granted if you are out of medication and have not yet received your drugs from a participating mail order pharmacy.

4.14.8 Prescription Drug 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 4.3.5);
2. Amphetamines and amphetamine derivatives except when used in the treatment of narcolepsy or attention deficit and/or hyperactivity disorder in children and adults;
3. Drugs prescribed that do not relate to the prevention or treatment of a covered illness or injury;
4. Drugs used for the treatment of fertility/infertility;
5. Fluoride, for Members over 16 years of age;
6. Drugs that are not provided in accordance with our formulary management program or are not provided according to our medical policy;
7. Drugs used in the treatment of fungal nail conditions;
8. 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;
9. Prescription drugs, including prescription combination drugs, that contain OTC products or are available in an OTC therapeutically similar form;
10. 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;
11. Drugs, which may include prescription combination drugs, placed on a prescription-only status as required by state or local law;
12. Replacement of lost or stolen medication;
13. Drugs or medicines used to treat sexual dysfunction (this exclusion does not apply to Mental Health Covered Services);
14. Drugs used in the treatment of drug-induced fatigue, general fatigue and idiopathic hypersomnia;
15. Drugs dispensed or compounded by a pharmacist that do not have at least one FDA-approved medication in therapeutic amount;
16. Drugs used for weight loss or for cosmetic purposes;
17. 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);
18. Prenatal vitamins that contain docosahexaenoic acid (DHA);

19. Drugs that are not FDA-approved or are designated as “less than effective” by the FDA (also known as “DESI” drugs);
20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC; and
21. 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.

4.14.9 Prescription Drug Disclaimer

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

5. EXCLUSIONS

In addition to those Services listed as not covered in section 4, 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;
- Are not a Covered Service or relate to complications resulting from a Non-Covered Service, except for Services provided as Emergency Care as described in section 4.5;
- Are not furnished by a Qualified Practitioner or Qualified Treatment Facility;
- Are provided by or payable under any health plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law;
- Are provided while you are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies, except to the extent provided by 38 U.S.C. § 1729 as it relates to non-military Services provided at a Veterans Administration Hospital or facility;
- Are provided while you are in the custody of any law enforcement authorities or while incarcerated, except as provided in section 3.3;
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos, books and educational programs to which drivers are referred by the judicial system, and volunteer mutual support groups;
- Are provided to yield primarily educational outcomes, except as otherwise covered under the Preventive Services benefit described in section 4.1. An outcome is "primarily educational" if the outcome's fundamental, first, or principal character is to provide you with enduring knowledge, skill, or competence through a process of repetitive positive reinforcement over an extended length of time. An outcome is "enduring" if long-lasting or permanent;
- Are performed in association with a Service that is not covered under this Plan, except Emergency Services;
- Are provided for any injury or illness that is sustained by any Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the Member. This exclusion also applies to injuries and illnesses that are the subject of a claim settlement 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. This exclusion also applies to charges applied to the deductible of such contract or insurance. Any benefits or Services provided under this Plan that are subject to this exclusion are provided solely to assist you and such assistance does not waive our right to reimbursement or subrogation as specified in section 6.3. This exclusion also applies to Services and supplies after you have received proceeds from a settlement as specified in section 6.3.3;
- Are provided in an institution that specializes in treatment of developmental disabilities, except as provided in section 4.10.2;
- Are provided for treatment or testing required by a third party or court of law which is not Medically Necessary;
- Are Experimental/Investigational;
- Are determined by us not to be Medically Necessary for diagnosis and treatment of an injury or illness;
- Are received by a Member under the Oregon Death with Dignity Act;
- Have not been Prior Authorized as required by this Plan; and
- Relate to any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member, if such Member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony or misdemeanor punishable by up to a year's imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or mental health condition);

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 4.13;
- Services for Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment (DME), except as described in section 4.9;
- Charges for Services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to, air conditioners, air purifiers, vacuum cleaners, motorized transportation equipment, escalators, elevators, tanning beds, ramps, waterbeds, hypoallergenic mattresses, cervical pillows, swimming pools, whirlpools, spas, exercise equipment, gravity lumbar reduction chairs, home blood pressure kits, personal computers and related equipment or other similar items or equipment;
- Physical therapy and rehabilitative Services, except as provided in sections 4.6.3 and 4.7.2;

- "Telephone visits" by a physician or "environment intervention" or "consultation" by telephone for which a charge is made to the patient, except as covered in section 4.3.2
- "Get acquainted" visits without physical assessment or diagnostic or therapeutic intervention provided and online treatment sessions;
- Missed appointments;
- Non-emergency medical transportation;
- Allergy shots and allergy serums, except as provided in section 4.3.5;
- All Services and supplies related to the treatment of obesity or morbid obesity, except as provided in section 4.1.6;
- Services for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas, except as provided in section 4.1.6;
- Transportation or travel time, food, lodging accommodations and communication expenses except as provided in sections 3.8 and 4.13 and with our prior approval;
- Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
- Biofeedback, except as provided in section 4.12.16;
- Thermography;
- Homeopathic procedures;
- Comprehensive digestive stool analysis, cytotoxic food allergy test, dark-field examination for toxicity or parasites, EAV and electronic tests for diagnosis and allergy, fecal transient and retention time, Henshaw test, intestinal permeability, Loomis 24-hour urine nutrient/enzyme analysis, melatonin biorhythm challenge, salivary caffeine clearance, sulfate/creatinine ratio, urinary sodium benzoate, urine/saliva pH, tryptophan load test, and zinc tolerance test;
- Chiropractic manipulation and acupuncture, except as provided in sections 4.12.9 and 4.12.10;
- Light therapy for seasonal affective disorder, including equipment;
- Any vitamins, dietary supplements, and other non-prescription supplements, except as required by federal or Oregon state law;
- Services for genetic testing are excluded, except as provided in section 4.12.1. Genetic testing is not covered for screening, to diagnose carrier states, or for informational purposes in the absence of disease;
- Services to modify the use of tobacco and nicotine, except as provided in section 4.1.8 or when provided as Extra Values or Discounts (see our website at www.ProvidenceHealthPlan.com), where available;
- Cosmetic Services including supplies and drugs, except as approved by us and described in section 4;
- Services, including routine physical examination, immunizations and vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel;
- Non-sterile examination gloves;
- Sales taxes, handling fees and similar surcharges, as explained in the definition of UCR;

- Air ambulance transportation for non-emergency situations is not covered, except as provided in section 4.5.2;
- Treatments that do not meet the national standards for Mental Health and Substance Abuse professional practice;
- Services provided under a court order or as a condition of parole or probation or instead of incarceration which are not Medically Necessary;
- Personal growth services such as assertiveness training or consciousness raising;
- School counseling and support services, peer support services, tutor and mentor services; independent living services, household management training, and wraparound services that are provided by a school or halfway house and received as part of an 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;
- Speech therapy, physical therapy and occupational therapy services provided in connection with treatment of psychosocial speech delay, learning disorders, including mental retardation and motor skill disorders, and educational speech delay including delayed language development (except as provided in sections 4.6.3 and 4.7.2);
- Counseling related to family, marriage, sex and career including, but not limited to, counseling for adoption, custody, family planning or pregnancy, in the absence of a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis;
- Neurological Services and tests including, but not limited to, EEGs, PET, CT, MRA and MRI imaging Services, and beam scans (except as provided in section 4.4.1);
- Vocational, pastoral or spiritual counseling;
- Viscosupplementation (i.e., hyaluronic acid/hyaluronan injection);
- All Direct-to-Consumer testing products; and
- Dance, poetry, music or art therapy, except as part of an approved treatment program.

Exclusions that apply to Provider Services:

- Services of homeopaths; faith healers; or lay, unlicensed direct entry, and certified professional midwives; and
- Services of any unlicensed providers.

Exclusions that apply to Reproductive Services:

- All services related to sexual disorders or dysfunctions regardless of gender or cause (this exclusion does not apply to Mental Health Covered Services);
- All of the following services:
    - All services related to surrogate parenting, except Maternity Services as described in section 4.8;
    - All services related to in vitro fertilization, including charges for egg/semen harvesting and storage;

- All services related to artificial insemination, including charges for semen harvesting and storage;
- All services and prescription drugs related to fertility preservation;
- Diagnostic testing and associated office visits to determine the cause of infertility;
- All of the following services when provided for the sole purpose of diagnosing and treating an infertile state or artificial reproduction:
  - Physical examination;
  - Related laboratory testing;
  - Instruction;
  - Medical and surgical procedures, such as hysterosalpingogram, laparoscopy, or pelvic ultrasound; and
  - Related supplies and prescriptions.

For the purpose of this exclusion:

- Infertility or infertile means the failure to become pregnant after a year of unprotected intercourse or the failure to carry a pregnancy to term as evidenced by three consecutive spontaneous abortions.
- Artificial reproduction means the creation of new life other than by the natural means;

- Termination of pregnancy, unless there is a severe threat to the mother, or if the life of the fetus cannot be sustained;
- Reversal of voluntary sterilization;
- Male condoms and other over-the-counter birth control products for men; 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; and
- Orthoptics and vision training.
- Services for routine eye care and vision care, vision exams/screenings, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in sections 4.1.1, 4.1.5, 4.5.3 and 4.9.2.

Exclusions that apply to Hearing Services:

- Replacement of lost or broken hearing aids are generally not covered, except for one time if a loss or damage claim is made within the first year of purchase;
- Repair of hearing aids outside of the warranty period are not covered. Repair needs during your warranty period should be discussed with your provider;
- Hearing aids prescribed and ordered prior to coverage, or prescribed or ordered after termination of coverage, whichever occurs first; and
- Hearing aids, hearing therapies and/or devices, except as provided in section 4.12.14.

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 us and described in sections 4.12.6;
- Services for orthognathic surgery, except as approved by us and described in section 4.12.6;
- Services to treat temporomandibular joint syndrome (TMJ), except as provided in section 4.12.7; and
- Dentures and orthodontia, except as provided in sections 4.12.6.

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 4.9.2.

Exclusions that apply to Prescription Drugs, Medicines and Devices:

- In addition to the exclusions listed in section 4.14.8; 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.

6. 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.

6.1 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 is not a bill. An EOB explains how Providence Health Plan processed your claim, and will assist you in paying the appropriate Member responsibility to your provider. Copayment or Coinsurance amounts, Deductible amounts, services or amounts not covered and general information about our processing of your claim are explained on an EOB.

Time Frames for Processing Claims

If 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 if 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, you will be sent a separate request for the information and you will have 45 days to submit the additional information. Once the additional information from you 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 additional information is needed to process the request, Providence Health Plan will provide written notice to the Member and the provider within two business days of receiving the Prior Authorization request. The Member and the provider will have 15 days to submit the additional information. Within two business days of receipt of the additional information, Providence Health Plan will complete 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 24 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.

6.1.1 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 (i.e., a Coordinated Care Organization) will be made in accordance with ORS 743B.470, which establishes payment requirements for claims submitted by the Oregon state Medicaid agency.

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

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

6.1.2 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.

6.2 COORDINATION OF BENEFITS

This Coordination of Benefits (COB) section applies when a Member has health care coverage under more than one Plan. The term "Plan" is defined below for the purposes of this COB section. The order of benefit determination rules 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.

6.2.1 Definitions Relating to Coordination of Benefits

Plan

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

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

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

This Plan

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

dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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

When This Plan is primary, Providence Health Plan determines payment for benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, Providence Health Plan determines benefits after those of another Plan and may reduce the benefits payable 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.

6.2.2 Order of Benefit Determination Rules

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

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

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

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

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

b) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   i. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
   ii. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
   iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
   iv. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the Dependent child are as follows:
      - The Plan covering the Custodial parent, first;
      - The Plan covering the spouse of the Custodial parent, second;
      - The Plan covering the non-custodial parent, third; and then
      - The Plan covering the Dependent spouse of the non-custodial parent, last.

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

d) For a Dependent child:
   i. Who has coverage under either or both parents' plans and also has coverage as a Dependent under a spouse's plan, the rule in paragraph (5) applies.
   ii. In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Subparagraph (a) to the Dependent child's parent(s) and the Dependent's spouse.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a Member as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same Member as a retired or laid-off employee is the Secondary plan. The same would hold true if a Member is a Dependent of an active employee and that same Member is a

Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a Member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the Member as an employee, subscriber or retiree or covering the Member as a Dependent of an employee, Subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the Member the longer period of time is the Primary plan and the Plan that covered the Member the shorter period of time is the Secondary plan.
6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than would have paid had This Plan been the Primary plan.

6.2.3 Effect on the Benefits of This Plan

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

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

6.2.4 Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply this COB section and to determine benefits payable under This Plan and other Plans. Providence Health Plan may get the facts needed from, or give them to, other organizations or persons for the purpose of applying this section and determining benefits payable under This Plan and other Plans covering a Member claiming benefits. Providence Health Plan 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 Providence Health Plan needs to apply this section and determine benefits payable.

6.2.5 Facility of Payment

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

6.2.6 Right of Recovery

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

6.2.7 Coordination with Medicare

In all cases, coordination of benefits with Medicare will conform with federal statutes and regulations. Medicare means Title XVIII of the Social Security Act, as enacted or amended. Medicare eligibility and how This Plan determines benefit limits 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.

6.3 THIRD-PARTY LIABILITY/SUBROGATION

The following provisions will apply when you or any other Member has received Services for a condition for which one or more third parties may be responsible. "Third party" means any person other than the Member (the first party to the provisions of this Plan), 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 us 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 9.4. 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 the Plan under these provisions.

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

Third-party liability refers to claims that are in whole or part the responsibility of someone besides the 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, the Plan 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 the Plan makes claim payments 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 the 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, the Plan is 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 has a security interest in and lien upon any recovery to the extent of the amount of benefits paid by the Plan and for the Plan's expenses in obtaining a recovery. If the Member should either decline to pursue a claim against a third party that the Plan believes is warranted or refuse to cooperate with the Plan in any third party claim that the Member does pursue, the Plan has 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, the Plan needs 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 Providence Health Plan office. A Providence Health Plan employee who specializes in third-party liability/subrogation can discuss these procedures and what you or the Member needs to do.

6.3.2 Proceeds of Settlement or Recovery

Subject to paragraph 6.3.4 below, if for any reason 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 the Plan 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 the Plan for the condition, calculated using the 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 the Plan's first priority to this repayment and assigns to us 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 the Plan. 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 the Plan directly from the settlement or recovery in the amount provided by this section.

The Member must complete the Plan's trust agreement, by which the Member and any Member's attorney (or other agent) must confirm the obligation to reimburse the Plan 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 the Plan. The agreement must remain in effect and the Plan 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 the Plan to exercise the Plan's rights under this section, it serves as a reminder to the Member and directly obligates any Member's attorney to act in accord with the Plan's rights.

6.3.3 Suspension of Benefits and Reimbursement

Subject to paragraph 6.3.4 below, after the Member has received proceeds of a settlement or recovery from the third party, the Member is responsible for payment of all medical expenses for the continuing treatment of the illness or injury that 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 the Plan as required by this section, the Plan is entitled to offset future benefits otherwise payable under this Plan, or under any future contract or plan with Clackamas County, 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 the 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 the 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 the Plan has not approved in advance. In no event shall the amount reimbursed to the Plan be less than the maximum permitted by law.

6.3.4 Special Rules for Motor Vehicle Accident Cases

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

Before the Plan will be entitled to recover 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.

7. PROBLEM RESOLUTION

7.1 INFORMAL PROBLEM RESOLUTION

All employees of Providence Health Plan share responsibility for assuring Member satisfaction. If you have a problem or concern about your coverage, including benefits or Services by In-Network Providers or payment for Services by Out-of-Network Providers, please ask for Providence Health Plan's 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, Providence Health Plan will make efforts to accommodate your requirements. Please contact Customer Service for help with whatever special needs you may have.

7.2 MEMBER GRIEVANCE AND APPEAL

Definitions:

Adverse Benefit Determination

An Adverse Benefit Determination means a:

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

Appeal

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

Authorized Representative

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

Concurrent Care

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

Grievance

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

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

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

7.2.1 Your Grievance and Appeal Rights

If you disagree with Providence Health Plan's decision about your medical bills or health care services, you have the right to an 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 Providence Health Plan will consider that information in the 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 by. We will acknowledge all non-urgent pre-service and post-service Grievance and Appeals within seven days of receipt and resolve within 30 days or sooner depending on the clinical urgency. Urgent medical conditions and concurrent care have different resolution timelines as noted below.

Urgent Medical Conditions: If you believe your health would be seriously harmed by waiting for Providence Health Plan's 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, you will be notified of the 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 reconsideration of the decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. Providence Health Plan will then notify you of the reconsideration decision within 24 hours of receiving your request.

7.2.2 Internal Grievance or Appeal

You must file your internal Grievance or Appeal within 180 days of the date on the notice of the initial Adverse Benefit Determination, or that initial determination will become final. Please advise Providence Health Plan of any additional information that you want considered in 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 for the review process. Your Grievance or Appeal will be reviewed by Providence Health Plan staff not involved in the initial determination. You may present your case in writing. Once a final determination is made you will be sent a written explanation of the decision.

7.2.3 External Review

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

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

The Plan pays for all costs for the handling of external review cases and Providence Health Plan administers these provisions in accordance with the insurance laws and regulations of the State of Oregon. **If we do not comply with the IRO decision, you have the right to sue us under applicable Oregon law.**

7.2.4 How to Submit Grievances or Appeals and Request Appeal Documents

To submit your Grievance or Appeal or requests for External Review, you may contact Customer Service at 503-574-7500 or 800-878-4445. If you are hearing impaired and use a Teletype (TTY) Device, please call the TTY line at 711. Written Grievances or Appeals should be sent to:

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

You may fax your Grievance or Appeal 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

If your plan is governed by ERISA, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). If your plan is not governed by ERISA, you may contact the Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789.

8. 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 and your Employer must provide Providence Health Plan with evidence of eligibility as requested.

8.1 EMPLOYEE ELIGIBILITY AND ENROLLMENT

8.1.1 Employee Eligibility Date

An employee is eligible for coverage as specified in the Eligible Employee definition.

8.1.2 Employee Effective Date

Coverage begins for an Eligible Employee as specified in the Effective Date of Coverage definition.

8.1.3 Employee Enrollment

The Eligible Employee must enroll on forms (paper or electronic) provided and/or accepted by Clackamas County. To obtain coverage, an Eligible Employee must enroll within 30 days to enroll after becoming eligible. An enrolled Eligible Employee is referred to as the Subscriber.

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.

In certain situations, you and/or your Eligible Family Dependents may qualify to enroll during a special enrollment period. See section 8.3 for additional information.

8.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

8.2.1 Eligibility Date

Coverage begins for each Eligible Family Dependent on:

1. The Effective Date of Coverage for the Subscriber if the individual is an Eligible Family Dependent on that date;
2. For any Eligible Family Dependents acquired on the date of the Subscriber's marriage, on the first day of the calendar month following receipt of the enrollment request, within 60 days of the Subscriber's marriage;
3. The date of birth of the biological child of the Subscriber or Spouse;
4. The date a child is placed with the Subscriber or Spouse for the purpose of adoption by the Subscriber or Spouse;
5. The date the Subscriber or Spouse is required to provide health coverage to a child under a qualified medical child support court or administrative order; or
6. The date on which legal guardianship status begins.

8.2.2 Additional Requirements for Eligible Family Dependent Coverage

An Eligible Employee may cover Eligible Family Dependents ONLY if the Eligible Employee is also covered, and Clackamas County receives the completed enrollment form requesting Dependent coverage.

8.2.3 Eligible Family Dependent Enrollment

You must enroll Eligible Family Dependents on forms provided and/or accepted by Clackamas County. No Eligible Family Dependent will become a Member until Clackamas County approves that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within 30 after becoming eligible as indicated in section 8.2.1 (see section 8.2.4 regarding newborn and adopted children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 8.3.

8.2.4 Newborn Eligibility and Enrollment

A newborn or adopted child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption as long as enrollment occurs within 60 days from birth or placement and additional Premium, if any, is paid to Clackamas County. 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 8.2.3 and 8.3.

8.2.5 Open Enrollment Period

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

8.2.6 Changes in Eligibility

When an eligibility change occurs, you need to make sure Clackamas County is notified of the change. Address changes can be made over the phone by calling Customer Service or by contacting Clackamas County Benefits & Wellness.

For the following changes, you, as the Subscriber, must obtain an enrollment form from Clackamas County's benefit office. You need to submit this form to your Employer for you and all your Eligible Family Dependents when:

- You marry and wish to enroll your new Spouse;
- A Dependent's limiting age occurs; or
- You or one of your Dependents has a legal name change.

If you have questions regarding eligibility changes, please contact Clackamas County Benefits & Wellness.

8.2.7 Members No Longer Eligible for Coverage

If you divorce or are legally separated, your Spouse is no longer eligible for coverage as a Dependent. You must disenroll your Spouse as a Dependent from your Plan at the time the divorce or legal separation is final. Your Spouse's children will be able to continue coverage under the Plan so long as the children continue to qualify as your Eligible Family Dependents.

You must inform Clackamas County of these changes by completing a new enrollment form. Check with Clackamas County's benefits office or contact Customer Service 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 section 10. Ask Clackamas County or call Customer Service for continuation coverage eligibility information.

8.3 SPECIAL ENROLLMENT PERIODS

If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your Spouse) during a previous enrollment period (as stated in sections 8.1 and 8.2), you may be eligible to enroll yourself or the Eligible Family Dependent during a "special enrollment period" provided that you request enrollment within 60 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
- Enroll in any benefit option offered by the Employer for which the Subscriber and Eligible Family Dependent is eligible.

8.3.1 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, the Plan 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 the Plan 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 benefits; and the individual applies for coverage under this Plan within 60 days after the claim is denied.

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

8.3.2 New 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, birth, adoption or placement for adoption; the Plan 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 60 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.

Effective Date:

- in the case of marriage, on the first day of the calendar month following Clackamas County's receipt of the enrollment request, or on an earlier date as agreed to by Clackamas County; 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.

8.3.3 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 or minor child under your Health Benefit Plan, the Plan 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 60 days after the issuance of the court order.

Effective Date: The date specified in the court order.

8.3.4 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 arrangement, the Plan 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.

8.4 LEAVE OF ABSENCE AND LAYOFFS

A Subscriber on leave of absence or layoff status may continue to be covered under this Plan as though actively at work for a period of time, if any, as stated in the Eligible Employee definition. An Employee who returns to work as an Eligible Employee after coverage has lapsed must re-enroll for coverage as specified in section 8.1.3

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), is administered in accordance with those Acts and this Summary Plan Description.

9. TERMINATION OF MEMBER COVERAGE

9.1 TERMINATION DATES

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 Clackamas County;
3. The last day of the coverage period in which a Subscriber no longer qualifies as a Subscriber, as stated in the Summary Plan Description;
4. The date a Member enters full-time military, naval or air service, except as provided under federal USERRA requirements;
5. The last day of the coverage period in which a Subscriber retires;
6. 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;
7. For a Family Member, the date the Subscriber's coverage terminates;
8. For a Family Member, the last day of the month in which the individual no longer qualifies as an Eligible Family Dependent;
9. For any benefit, the date the benefit is deleted from this Plan;
10. For a Member, the date of disenrollment from this Plan as described in section 9.4;
11. For a Member, the date any fraudulent information is provided; or
12. For a Member, the date we discover any breach of contractual duties, conditions or warranties, as determined by us.
13. For a Subscriber that is a Non-Medicare Eligible Early Retiree, the last day of the month in which the Retiree becomes eligible for Medicare.

You and the Employer are responsible for advising Clackamas County 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 Clackamas County.

See section 7, Problem Resolution, for your Grievance and Appeal rights.

9.2 TERMINATION AND RESCISSION OF COVERAGE DUE TO FRAUD OR ABUSE

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

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

9.3 NON-LIABILITY AFTER TERMINATION

Upon termination of this Plan, Clackamas County shall have no further liability beyond the effective date of the termination unless the Member continues, without lapse of membership, under another Clackamas County plan.

9.4 DISENROLLMENT FROM THIS PLAN

"Disenrollment" means that your coverage under this Plan is terminated 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 Clackamas County or Providence Health Plan employees; or
4. You have allowed a non-Member to use your Member ID Card to obtain Services.

9.5 NOTICE OF CREDITABLE COVERAGE

Providence Health Plan will provide upon request written certification of the Member's period of Creditable Coverage when:

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

9.6 CLACKAMAS COUNTY'S RIGHT TO TERMINATE OR AMEND PLAN

Clackamas County 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 Clackamas County.

10. 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 and which are generally outlined below. Please contact Clackamas County as soon as possible for details if you think you may qualify for group COBRA or state continuation coverage.

10.1 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.

10.1.1 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.

10.1.2 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.

10.1.3 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 who is properly enrolled under the terms of this Plan during the COBRA continuation period will be a qualified beneficiary.

10.1.4 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 Clackamas County 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 Clackamas County 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.

10.1.5 Type of COBRA Continuation Coverage

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

10.1.6 COBRA Election Rights

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

10.1.7 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 Clackamas County 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.

10.1.8 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 their 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 Clackamas County 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 Dependent child 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.

10.1.9 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.

10.1.10 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/.

10.1.11 When COBRA Continuation Coverage Ends

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

- Clackamas County 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;
- 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.

11. MEMBER RIGHTS AND RESPONSIBILITIES

11.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES

As a Member of Providence Health Plan, you should know what to expect from Providence Health Plan, as well as what Providence Health Plan asks from you. Nobody knows more about your health than you and your doctor. Providence Health Plan takes 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. Providence Health Plan wants you to have a positive experience, and 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, the providers, and the benefits and Services you have available to you as a Member.
- Receive information that helps you select a Qualified Practitioner whom you trust and with whom you feel comfortable.
- A candid discussion of appropriate or Medically Necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Receive information and clinical guidelines from your health care provider or your health plan that will enable you to make thoughtful decisions about your health care.
- Actively participate in decisions that relate to your health and your medical care through discussions with your health care provider or through written advance directives.
- Have access to medical Services that are appropriate for your needs.
- Express a concern or an Appeal and receive a timely response from Providence Health Plan.
- Have your claims paid accurately and promptly.
- Request a review of any service not approved, and to receive prompt information regarding the outcome.
- Be informed about and make recommendations regarding Providence Health Plan's member rights and responsibilities policy.
- Refuse care from specific providers.

Members have the responsibility to:

- Read and understand the information in and the terms of your Plan. Neither the Plan nor Providence Health Plan will have liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact Customer Service. Providence Health Plan will assist you in understanding and complying with the terms of the Plan.
- Talk openly with your physician or provider, understand your health problem and work toward a relationship built on mutual trust and cooperation.
- Develop mutually agreed upon treatment goals with your Qualified Practitioner, to the degree possible, and follow treatment plans and instructions.
- Supply to the extent possible information Providence Health Plan 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 Customer Service know if you have concerns or if you feel that any of your rights are being compromised, so that Providence Health Plan can act on your behalf.
- Call or write within 180 days of Service if you wish to request a review of Services provided or Appeal a Providence Health Plan decision.
- Notify Customer Service if your address changes.

Providence Health Plan has the responsibility to:

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

11.2 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 Clackamas County's Group Plan, you are entitled to certain rights and protections under Oregon law, which provides that all Plan participants are entitled to:

1. **Receive from Providence Health Plan information maintained about you by your Employer's group plan**
    - You are entitled within 30 days to access to recorded personal information, 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 10.1.
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 7, the Plan offers 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 7.2 of this Summary Plan Description. If the Member elects to seek external review under section 7.2.4, both the Plan and the Member will be bound by the Independent Review Organization (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 7.2.

    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 or an arbitrator, neither party shall under any circumstance be liable to the other for any special, incidental, or consequential damages, or for any tort liability (including any punitive or exemplary damages), in any way related to this Plan.

12. 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.

12.1 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 Clackamas County has determined satisfies the QMSCO standards set forth below.

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

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

12.2 NOTICE UPON RECEIPT OF ORDER

Upon the receipt of any Order, Clackamas County 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.

12.3 NOTICE OF DETERMINATION

Within a reasonable period after its receipt of the Order, Clackamas County 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, the Order will not be considered to be a QMCSO.

12.4 ENROLLMENT OF ALTERNATE RECIPIENT

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

12.5 COST OF COVERAGE

An Alternate Recipient will be treated as having been 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.

12.6 REIMBURSEMENT OF PLAN EXPENSES

Unless the terms of the Order provide otherwise, any payments to be from the Plan as reimbursement for group health expenses paid either by the Alternate Recipient, or by the custodial parent or legal guardian of the Alternate Recipient, will not be paid to the 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.

12.7 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.

12.8 TREATMENT OF NATIONAL MEDICAL SUPPORT NOTICE

If Clackamas County 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 Clackamas County to satisfy the QMCSO standards prescribed above, then the National Notice shall be deemed to be a QMSCO respect to such child.

Clackamas County, upon determining that the National Notice is a QMSCO, 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.

Clackamas County 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.

13. GENERAL PROVISIONS

13.1 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.

13.2 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.

13.3 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.

13.4 FAILURE TO PROVIDE INFORMATION OR PROVIDING INCORRECT OR INCOMPLETE INFORMATION

Members warrant that all information contained in applications, questionnaires, forms, or statements submitted to Clackamas County and to Providence Health Plan to be true, correct, and complete. If a Member willfully fails to provide information required to be provided under this Plan or knowingly provides incorrect or incomplete information, then the Member's rights may be terminated. See section 9.4.

13.5 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.

13.6 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.

13.7 LEGAL ACTION

No civil action may be brought under state or federal law to recover benefits from the Plan until receipt of a final decision under the Member Grievance and Appeal process specified in section 7.2 of the Summary Plan Description, unless the Member's benefits under the Plan are subject to the Employee Retirement Income Security Act (ERISA), in which case the Member is permitted either to bring a civil action under ERISA in federal court after receiving a decision from the First Level of Appeal or to bring such an action after receipt of a final grievance decision. An appeal from a final Grievance decision may lie with an Independent Review Organization (IRO). In the event a right to IRO review exists and the Member elects to seek such review, the IRO decision will be binding and final, as indicated in section 7.2.4. No civil action under ERISA or otherwise 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 7.2. If ERISA does not apply (see section 11.2) the action must be brought in Oregon state court, either in the Member's county of residence or such other county as mutually agreed upon between Member and the Plan. In general, ERISA applies if this is an employer-sponsored plan, other than a government plan or church plan.

13.8 LIMITATIONS AND 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 Clackamas County shall be paid solely in accordance with the terms and provisions of such plan, and nothing in this Plan shall operate or be construed in any way to modify, amend, or affect the terms and provisions of such other plan.

13.9 MEMBER RESPONSIBILITY

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

13.10 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.

13.11 NON-TRANSFERABILITY OF BENEFITS

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

13.12 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 Clackamas County. No shareholder, director, officer, or employee of Clackamas County 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.

13.13 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 Clackamas County nor Providence Health Plan is liable for any claim or demand due to damages arising out of, or in any manner connected with, any injuries suffered by you while receiving such Services.

13.14 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.

13.15 NOTICE

Any notice required of Clackamas County or Providence Health Plan under this Plan shall be deemed to be sufficient if mailed to the Subscriber at the address appearing in 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, P.O. Box 3125, Portland, OR 97208.

13.16 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 6.1.1 regarding timely submission of claims.

13.17 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. PHP'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 Clackamas County and Providence Health Plan.

13.18 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.

13.19 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 our 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.

13.20 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.

13.21 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 Clackamas County to deduct the overpayment from future benefit payments under this Plan.

13.22 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.

13.23 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.

13.24 SUGGESTIONS

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

13.25 VETERANS' RIGHTS

The Plan will provide benefits to employees 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) An employee who takes unpaid military leave, or who separates from the employment of Clackamas County 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 10 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 employee's absence for the purpose of performing military service begins; or
    2. The date the employee fails to timely return to employment or reapply for a position with Clackamas County upon the completion of such military service.

13.26 WORKERS' COMPENSATION INSURANCE

This Plan is not in lieu of, and does not affect, any requirement for coverage under any workers' compensation act or similar law.

14. PLAN ADMINISTRATION

14.1 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. 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.

14.2 PLAN INFORMATION

Plan Name: Clackamas County General County Employees Personal Option Plan
Plan No. 10112
Employer ID No. 936002286

14.3 PLAN DATES

The effective date of the Plan is January 1st and ends on December 31st.

14.4 PLAN SPONSOR INFORMATION

Clackamas County
Benefits & Wellness Division
Public Services Building
2051 Kaen Road, Suite 310
Oregon City, OR 97045
503-655-8459

14.5 ADMINISTRATIVE SERVICES PROVIDED BY

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

14.6 AGENT FOR SERVICE OF LEGAL PROCESS

Clackamas County
Office of County Counsel
2051 Kaen Rd.
Oregon City, OR 97045

14.7 ADMINISTRATIVE SERVICES

The Employer 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.

14.7.1 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.

14.8 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.

14.9 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.

14.10 AMENDMENT OR TERMINATION OF PLAN

14.10.1 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.

14.10.2 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 Chair of the Board of County Commissioners or their designee shall be conclusive evidence of the adoption and effectiveness of the instrument.

14.10.3 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.

14.11 PROTECTED HEALTH INFORMATION

14.11.1 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 PHI obtained from Providence Health Plan 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. Benefit Managers;
    3. Benefit Analysts;
    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.

14.11.2 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 14.11.1(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.

15. DEFINITIONS

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

Adverse Benefit Determination
See section 7.

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

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

Annual
Annual means once per Calendar Year.

Appeal
See section 7.

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

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

Authorized Representative
See section 7.

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

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

Chemical Dependency
Chemical Dependency 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 Abuse does not mean an addiction to, or dependency on tobacco, tobacco products or foods.

Clackamas County
Clackamas County means the entity that is the Sponsor of this Plan.

Clackamas County General County Employees Personal Option Plan
Clackamas County General County Employees Personal Option Plan means this Summary Plan Description and includes the provisions of the Benefit Summaries and any Endorsements, amendments and addendums that accompany this document.

Cochlear Implant
See section 4.12.14.

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. Your Coinsurance for a Covered Service is shown in the Benefit Summary and is a percentage of the charges for the Covered Service. Your Coinsurance will usually be less when you receive Covered Services from an In-Network Provider.

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 section 4;
2. Medically Necessary;
3. Not listed as an Exclusion in the Benefit Summary or in sections 4 and 5; 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 3.13.1.

Dependent

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

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 with a member of the same sex; and
    - Has legally registered a Declaration of Domestic Partnership and obtained a Certificate of Registered Domestic Partnership in accordance with Oregon state law.
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 section4.3.3).

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

Eligibility Waiting Period
Eligibility Waiting Period means the period of employment, as specified in the Eligible Employee definition, that an otherwise Eligible Employee must complete before coverage will begin under this Plan. The Eligibility Waiting Period will not exceed 90 days. When the Eligibility Waiting Period is 90 days, coverage is effective on the 91st day. If an employee enrolls on a special enrollment date, any period before such special enrollment is not an Eligibility Waiting Period.

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 8.1.

1. Employment Status: Permanent. (On-call, temporary, substitute, and seasonal employees are not eligible.)
2. Employment Category/Class: Personal Option General County Employees, COBRA-participants and Non Medicare Eligible Early Retirees.
3. Work Hours: Regularly scheduled for at least 20 hours per week (18.75 hours per week for Job Share). Not applicable to COBRA and Early Retiree.

4. Eligibility Waiting Period: Two months.* A new Eligibility Waiting Period does not apply if an employee returns to work in eligible status from a period of layoff or leave of absence, provided that such period did not exceed 180 days. The Eligibility Waiting Period is also waived if an employee has continuously participated in COBRA continuation coverage during the layoff period and is rehired within 18 months from the date of layoff. (*Note: Effective July 1, 2021, the Eligibility Waiting Period for new employees hired on or after this date will be the first of the month following date of hire.)
5. Effective Date of Coverage: Active: First of the month following completion of the Eligibility Waiting Period. COBRA: First day following loss of Active coverage. Early Retiree: First of the month following retirement.
6. Location: Employees who work or reside in Oregon.
7. Leave of Absence Status: An otherwise Eligible Employee on an Employer-approved Leave of Absence shall remain eligible during the first six months of leave of absence. Absences extending beyond this period are subject to the COBRA and/or Portability provisions of this Summary Plan Description.
8. Layoff/Rehire: If the Eligible Employee is rehired within six months, the Eligibility Waiting Period is waived.
9. Retirement Status: Non-Medicare eligible retired employees are eligible.

Eligible Family Dependent

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

Placement for adoption means the assumption and retention by a Subscriber or Spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption). Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.

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;
2. Incapable of self-sustaining employment prior to the limiting age; and
3. Unmarried.

Proof of incapacity must be provided to us 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. Thereafter, Providence Health Plan 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 Providence Health Plan, the individual's coverage will not continue beyond the last date of eligibility.

See section 8.2.4 for information on when and how to add a newborn to the Plan.

Emergency Medical Condition
See section 4.5.1.

Emergency Medical Screening Exams
See section 4.5.1.

Emergency Services
See section 4.5.1.

Employer
Employer means Clackamas County, an Oregon employer, and the Plan Sponsor.

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

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

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental Health and substance use disorder (Substance Abuse) services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including dental and vision care.

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

Experimental/Investigational
Experimental/Investigational means Services for which current, prevailing, evidence-based, peer-reviewed medical literature does not demonstrate the safety and effectiveness of the Service for treating or diagnosing the condition or illness for which its use is proposed. In

determining whether Services are Experimental/Investigational the Plan considers a variety of criteria, which include, but are not limited to, whether the Services are:

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

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

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

Fiduciary
Fiduciary means a person entrusted to act on behalf of the Plan, consistent with the duties and obligations of plan administration as set forth under applicable law.

Global Fee
See section 4.13.2.

Grievance
See section 7.

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 Employee Retirement Income Security Act (ERISA).

Hearing Aid
See section 4.12.14.

Hearing Assistance Technology
See section 4.12.14.

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 Abuse or Mental Health disorders.

In-Network

In-Network means the level of benefits specified in the Benefit Summary and 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, Hospital, Qualified Practitioner, Qualified Treatment Facility, Skilled Nursing Facility, or Pharmacy that has a written agreement with Providence Health Plan to participate as a health care provider for this Plan. For Native American Indian and Alaskan Native Members, Covered Services obtained through Indian Health Services are considered to be Covered Services obtained from an In-Network Provider.

Ineligible Person

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

Late Enrollee

Late Enrollee means a person eligible to enroll under a Special Enrollment Period, as described in section 8.3.

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

Non-Medicare Eligible Early Retiree
Non-Medicare Eligible Early Retiree means a Subscriber who retires from employment with Clackamas County and is eligible to enroll in this Plan.

Open Enrollment Period
Open Enrollment Period means a period during each Plan Year, as established by Clackamas County, 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 the Benefit Summary and 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 for this Plan.

Out-of-Pocket Maximum
See section 3.12.2.

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

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

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

Plan
Plan means the Clackamas County group health plan, as set forth in this document, the Summary Plan Description, and includes the provisions of any Benefit Summary 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.

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 Qualified Practitioner specializing in obstetrics or gynecology; a nurse practitioner; a

certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider.

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

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 Providence Health Plan's 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, additional information may be required about the Member's condition and/or the Services requested. Providence Health Plan 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 Plan. Services that require Prior Authorization are shown in section 3.7.

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 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 corrects a congenital deformity or anomaly that results in a functional impairment.

Retail Health Clinic

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

Service
Service means a health care related procedure, surgery, consultation, advice, diagnosis, referral, treatment, supply, medication, prescription drug, device or technology that is provided to a Member by a Qualified Practitioner.

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 or non-Medicare Eligible Early Retiree of Clackamas County who is eligible for benefits and is properly enrolled in accordance with the provisions of this Summary Plan Description.

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

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

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

Usual, Customary and Reasonable (UCR)
When a Service is provided by an In-Network Provider, UCR means charges based on the fee that 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 determined, in Providence Health Plan's reasonable discretion, based on the lesser of:

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

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

Virtual Visit

Virtual Visit means a visit with an In-Network Provider using secure internet technology:

- Phone and Video Visit:
  Phone and Video Visit means a Medically Necessary and appropriate consultation through phone and video with an In-Network Provider using Providence Health Plan approved secure technology. A Phone and Video Visit must relate to the treatment of a covered illness or injury (see also section 4.3.2).
- Web-direct Visit:
  Web-direct Visit means a Medically Necessary consultation with an In-Network Provider utilizing an online questionnaire to collect information and diagnose common conditions such as cold, flu, sore throat, allergy, ear ache, sinus pain, or UTI (see also section 4.3.2).

Women's Health Care Provider

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

16. NON-DISCRIMINATION STATEMENT

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

Providence Health Plan and Providence Health Assurance:

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

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

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

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

Language Access Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 Clackamas County's self-funded Employee Health Benefit Plan, Clackamas County General County Employee Personal Option 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 Clackamas County'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, 2021.

By: _____

Printed Name: _____

Title: _____

Company: _____

Date: _____

Administered by

PROVIDENCE
Health Plan

Our Mission

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

Our Values

Compassion | Dignity | Justice | Excellence | Integrity

Questions? We're here to help.

Speak to one of our Customer Service representatives at 503-574-7500 or 800-878-4445 (TTY: 771); 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.

©2020 Providence Health Plan. All rights reserved.

Clackamas Co GCE Personal Option SPD
Effective January 01, 2021
Administered by Providence Health Plan

2021 Summary Plan Description

Peace Officers Association

Open Option Grandfathered

TABLE OF CONTENTS

1. INTRODUCTION 1

1.1 KEY FEATURES OF YOUR CLACKAMAS COUNTY PEACE OFFICERS ASSOCIATION OPEN OPTION GRANDFATHERED PLAN 2

1.2 GRANDFATHERED PLAN NOTICE 3

2. WELCOME TO PROVIDENCE HEALTH PLAN 4

2.1 CLACKAMAS COUNTY PEACE OFFICERS ASSOCIATION OPEN OPTION GRANDFATHERED PLAN 4

2.2 SUMMARY PLAN DESCRIPTION 4

2.3 CUSTOMER SERVICE 5

2.4 REGISTERING FOR A MYPROVIDENCE ACCOUNT 5

2.5 YOUR MEMBER ID CARD 5

2.6 PROVIDENCE NURSE ADVICE LINE 6

2.7 WELLNESS BENEFITS 6

2.8 PRIVACY OF MEMBER INFORMATION 8

3. HOW TO USE YOUR PLAN 10

3.1 IN-NETWORK PROVIDERS 10

3.1.1 Nationwide Network of In-Network Providers 10

3.1.2 Choosing an In-Network Provider 10

3.1.3 Indian Health Services Providers 11

3.2 THE ROLE OF A PRIMARY CARE PROVIDER 11

3.2.1 Primary Care Providers 11

3.2.2 Established Patients with Primary Care Providers 11

3.2.3 Selecting a New Primary Care Provider 12

3.2.4 Changing Your Primary Care Provider 12

3.2.5 Office Visits 12

3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS 13

3.4 NOTICE OF PROVIDER TERMINATION 15

3.5 PRIOR AUTHORIZATION 15

3.6 TRAVEL EXPENSE REIMBURSEMENT 17

3.7 MEDICAL COST MANAGEMENT 17

3.7.1 Coverage of New Technology and New Application of Existing Technology 18

3.8 MEDICALLY NECESSARY SERVICES 18

3.9 APPROVED CLINICAL TRIALS 19

3.10 HOW BENEFITS ARE APPLIED 19

3.11 DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS 19

3.11.1 Understanding Deductibles 20

3.11.2 Understanding Out-of-Pocket Maximums 20

4. COVERED SERVICES 22

4.1 PREVENTIVE SERVICES 22

4.1.1 Physical Examinations and Well-Baby Care 22

4.1.2 Immunizations and Vaccinations 23

4.1.3 Prostate Cancer Screening Exams 23

4.1.4 Colorectal Cancer Screening Exams 23
4.1.5 Preventive Services for Members with Diabetes 24
4.1.6 Diabetes Self-Management Education Program 24
4.1.7 Nutritional Counseling 24
4.1.8 Tobacco Use Cessation Services 24
4.2 WOMEN'S PREVENTIVE HEALTH CARE SERVICES 25
4.2.1 Gynecological Examinations 25
4.2.2 Mammograms 25
4.2.3 Breastfeeding Counseling and Support 25
4.2.4 Family Planning Services 25
4.3 PROVIDER SERVICES 26
4.3.1 Office Visits, Inpatient and Outpatient Hospital Visits, and Home Visits 26
4.3.2 Virtual Visits 26
4.3.3 E-mail Visits 26
4.3.4 Telemedical Services 27
4.3.5 Allergy Shots, Allergy Serums, Injectable and Infused Medications 28
4.3.6 Administration of Anesthesia and Surgical Procedures 28
4.3.7 Immediate Care 28
4.3.8 Retail Health Clinic 28
4.4 DIAGNOSTIC SERVICES 29
4.4.1 Diagnostic Pathology, Radiology Tests, High Tech Imaging and Diagnostic Procedures 29
4.4.2 Sleep Study Services 29
4.5 EMERGENCY CARE AND URGENT CARE SERVICES 29
4.5.1 Emergency Care 29
4.5.2 Emergency Medical Transportation 31
4.5.3 Emergency Eye Care Services 31
4.5.4 Emergency Detoxification Services 31
4.5.5 Urgent Care 31
4.6 INPATIENT HOSPITAL AND SKILLED NURSING FACILITY SERVICES 32
4.6.1 Inpatient Hospital Services 32
4.6.2 Skilled Nursing Facility 33
4.6.3 Inpatient Rehabilitative Care 33
4.6.4 Inpatient Habilitative Care 33
4.6.5 Observation Care 34
4.7 OUTPATIENT SERVICES 34
4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy, and Multidisciplinary Pain Management Programs 34
4.7.2 Outpatient Rehabilitative Services 34
4.7.3 Outpatient Habilitative Services 35
4.8 MATERNITY SERVICES 35
4.9 MEDICAL SUPPLIES, MEDICAL APPLIANCES, PROSTHETIC AND ORTHOTIC DEVICES AND DURABLE MEDICAL EQUIPMENT (DME) 36
4.9.1 Medical Supplies (including Diabetes Supplies) 37

4.9.2 Medical Appliances 37
4.9.3 Prosthetic and Orthotic Devices 38
4.9.4 Durable Medical Equipment (DME) 38
4.10 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES 38
4.10.1 Mental Health Services 38
4.10.2 Applied Behavior Analysis 38
4.10.3 Substance Abuse Services 39
4.11 HOME HEALTH AND HOSPICE CARE 40
4.11.1 Home Health Care 40
4.11.2 Hospice Care 40
4.12 OTHER COVERED SERVICES 41
4.12.1 Genetic Testing and Counseling Services 41
4.12.2 Inborn Errors of Metabolism 41
4.12.3 Podiatry/Foot Services 41
4.12.4 Reconstructive Surgery 42
4.12.5 Reconstructive Breast Surgery 42
4.12.6 Restoration of Head/Facial Structures; Limited Dental Services 42
4.12.7 Temporomandibular Joint (TMJ) Services 43
4.12.8 Self-Administered Chemotherapy 43
4.12.9 Gender Dysphoria 44
4.12.10 Elective Sterilization 44
4.12.11 Hearing Loss Services 44
4.12.12 Wigs 45
4.13 HUMAN ORGAN/TISSUE TRANSPLANTS 45
4.13.1 Covered Services 46
4.13.2 Benefits for Transplant Facility Services Provided to the Organ Recipient 46
4.13.3 Benefits for Outpatient Medications 47
4.13.4 Benefits for Physician/Provider Services Provided to the Organ Recipient 47
4.13.5 Transplant Prior Authorization 47
4.13.6 Transplant Exclusions 47
4.14 PRESCRIPTION DRUG BENEFIT 48
4.14.1 Using Your Prescription Drug Benefit 48
4.14.2 Use of Out-of-Network Pharmacies 49
4.14.3 Prescription Drug Formulary 50
4.14.4 Generic and Brand-Name Prescription Drugs 50
4.14.5 Prescription Drug Quantity 51
4.14.6 Participating Mail-Order and Preferred Retail Pharmacies 51
4.14.7 Prescription Drug Limitations 51
4.14.8 Prescription Drug Exclusions 52
4.14.9 Prescription Drug Disclaimer 53
4.15 CHIROPRACTIC CARE BENEFIT 53
4.15.1 Chiropractic Care Providers 53
4.15.2 Chiropractic Care Services 54
5. EXCLUSIONS 56
6. CLAIMS ADMINISTRATION 62

6.1 CLAIMS PAYMENT 62
6.1.1 Timely Submission of Claims 63
6.1.2 Right of Recovery 64
6.2 COORDINATION OF BENEFITS 64
6.2.1 Definitions Relating to Coordination of Benefits 64
6.2.2 Order of Benefit Determination Rules 66
6.2.3 Effect on the Benefits of This Plan 68
6.2.4 Right to Receive and Release Needed Information 68
6.2.5 Facility of Payment 69
6.2.6 Right of Recovery 69
6.2.7 Coordination with Medicare 69
6.3 THIRD-PARTY LIABILITY/SUBROGATION 70
6.3.1 Third-Party Liability/Subrogation and How It Affects You 70
6.3.2 Proceeds of Settlement or Recovery 71
6.3.3 Suspension of Benefits and Reimbursement 72
6.3.4 Special Rules for Motor Vehicle Accident Cases 72

7. PROBLEM RESOLUTION 73

7.1 INFORMAL PROBLEM RESOLUTION 73
7.2 MEMBER GRIEVANCE AND APPEAL 73
7.2.1 Your Grievance and Appeal Rights 74
7.2.2 Internal Grievance or Appeal 75
7.2.3 External Review 75
7.2.4 How to Submit Grievances or Appeals and Request Appeal Documents 76

8. ELIGIBILITY AND ENROLLMENT 77

8.1 EMPLOYEE ELIGIBILITY AND ENROLLMENT 77
8.1.1 Employee Eligibility Date 77
8.1.2 Employee Effective Date 77
8.1.3 Employee Enrollment 77
8.2 DEPENDENT ELIGIBILITY AND ENROLLMENT 77
8.2.1 Eligibility Date 77
8.2.2 Additional Requirements for Eligible Family Dependent Coverage 77
8.2.3 Eligible Family Dependent Enrollment 78
8.2.4 Newborn Eligibility and Enrollment 78
8.2.5 Open Enrollment Period 78
8.2.6 Changes in Eligibility 78
8.2.7 Members No Longer Eligible for Coverage 78
8.3 SPECIAL ENROLLMENT PERIODS 79
8.3.1 Loss of Other Coverage 79
8.3.2 New Dependents 80
8.3.3 Court Orders 80
8.3.4 Premium Assistance 80
8.4 LEAVE OF ABSENCE AND LAYOFFS 81

9. TERMINATION OF MEMBER COVERAGE 82

9.1 TERMINATION DATES 82

9.2 TERMINATION AND RESCISSION OF COVERAGE DUE TO FRAUD OR ABUSE 82
9.3 NON-LIABILITY AFTER TERMINATION 82
9.4 DISENROLLMENT FROM THIS PLAN 83
9.5 NOTICE OF CREDITABLE COVERAGE 83
9.6 CLACKAMAS COUNTY'S RIGHT TO TERMINATE OR AMEND PLAN 83
10. CONTINUATION OF GROUP MEDICAL BENEFITS 84
10.1 COBRA CONTINUATION COVERAGE 84
10.1.1 Subscriber's Continuation Coverage 84
10.1.2 Spouse's or Domestic Partner's Continuation Coverage 84
10.1.3 Dependent's Continuation Coverage 84
10.1.4 Notice Requirements 85
10.1.5 Type of COBRA Continuation Coverage 85
10.1.6 COBRA Election Rights 85
10.1.7 COBRA Premiums 85
10.1.8 Length of COBRA Continuation Coverage 85
10.1.9 Extension of Continuation Period 86
10.1.10 Trade Act of 2002 86
10.1.11 When COBRA Continuation Coverage Ends 87
11. MEMBER RIGHTS AND RESPONSIBILITIES 88
11.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES 88
11.2 INFORMATION FOR NON-ERISA MEMBERS (PARTICIPANTS) 89
12. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO) 91
12.1 DEFINITIONS 91
12.2 NOTICE UPON RECEIPT OF ORDER 91
12.3 NOTICE OF DETERMINATION 91
12.4 ENROLLMENT OF ALTERNATE RECIPIENT 92
12.5 COST OF COVERAGE 92
12.6 REIMBURSEMENT OF PLAN EXPENSES 92
12.7 STATUS OF ALTERNATE RECIPIENT 92
12.8 TREATMENT OF NATIONAL MEDICAL SUPPORT NOTICE 93
13. GENERAL PROVISIONS 94
13.1 CONFLICTS OF PROVISIONS 94
13.2 CONTROLLING STATE LAW 94
13.3 DUPLICATING PROVISIONS 94
13.4 FAILURE TO PROVIDE INFORMATION OR PROVIDING INCORRECT OR INCOMPLETE INFORMATION 94
13.5 GENDER AND NUMBER 94
13.6 HEADINGS 94
13.7 LEGAL ACTION 95
13.8 LIMITATIONS AND PROVISIONS 95
13.9 MEMBER RESPONSIBILITY 95
13.10 MEMBERSHIP ID CARD 95
13.11 NON-TRANSFERABILITY OF BENEFITS 95
13.12 NO GUARANTEE OF EMPLOYMENT 95

13.13 NO RECOURSE FOR ACTS OF PROVIDERS 96
13.14 NON-WAIVER 96
13.15 NOTICE 96
13.16 NOTICE REQUIRED FOR REIMBURSEMENT AND PAYMENT OF CLAIM 96
13.17 PAYMENT OF BENEFITS TO PERSONS UNDER LEGAL DISABILITY 96
13.18 PHYSICAL EXAMINATION AND AUTOPSY 97
13.19 PROFESSIONAL REVIEW AND RIGHT TO EXAMINE RECORDS 97
13.20 REQUIRED INFORMATION TO BE FURNISHED 97
13.21 RIGHT OF RECOVERY 97
13.22 SEVERABILITY 97
13.23 STATE MEDICAID BENEFITS RIGHTS 98
13.24 SUGGESTIONS 98
13.25 VETERANS' RIGHTS 98
13.26 WORKERS' COMPENSATION INSURANCE 98
14. PLAN ADMINISTRATION 99
14.1 TYPE OF ADMINISTRATION 99
14.2 PLAN INFORMATION 99
14.3 PLAN DATES 99
14.4 PLAN SPONSOR INFORMATION 99
14.5 ADMINISTRATIVE SERVICES PROVIDED BY 99
14.6 AGENT FOR SERVICE OF LEGAL PROCESS 99
14.7 ADMINISTRATIVE SERVICES 100
14.7.1 Complete Allocation of Fiduciary Responsibilities 100
14.8 ENGAGEMENT OF ADVISORS 100
14.9 INDEMNIFICATION 100
14.10 AMENDMENT OR TERMINATION OF PLAN 100
14.10.1 Right to Amend or Terminate 100
14.10.2 Manner of Action 101
14.10.3 Effect on Benefits 101
14.11 PROTECTED HEALTH INFORMATION 101
14.11.1 Disclosure 101
14.11.2 Security 102
15. DEFINITIONS 103
16. NON-DISCRIMINATION STATEMENT 116

1. INTRODUCTION

Statement from Plan Sponsor

Clackamas County has designed this Plan in cooperation with Providence Health Plan. The benefits under the Plan are provided by Clackamas County on a self-insured basis. Clackamas County 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.

Clackamas County Benefits & Wellness: 503-655-8550

Customer Service Quick Reference Guide:

Medical 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 Chemical Dependency 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)
Providence Resource Line To find a care provider or to register for Providence classes	503-574-6595
myProvidence Help Desk	503-216-6463 877-569-7768 (toll-free)
LifeBalance	503-234-1375 888-754-LIFE (toll-free) www.LifeBalanceProgram.com
Provider Directory	ProvidenceHealthPlan.com/findaprovider

1.1 KEY FEATURES OF YOUR CLACKAMAS COUNTY PEACE OFFICERS ASSOCIATION OPEN OPTION GRANDFATHERED PLAN

- Some capitalized terms have special meanings. Please see section 15, Definitions.
- In this Summary Plan Description, Providence Health Plan and Clackamas County 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;
  - Providence Health Plan's 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 3 and your Plan Benefit Summary for additional information.
- Some Services are covered only under your In-Network benefits:
  - Web-direct Visits, as specified in section 4.3.2;
  - E-mail Visit Services, as specified in section 4.3.3;
  - Temporomandibular Joint (TMJ) Services, as specified in section 4.12.7;
  - Tobacco Use Cessation Services, as specified in section 4.1.8;
  - Human Organ/Tissue Transplant Services, as specified in section 4.13; and
  - Any item listed in your Benefit Summary as "Not Covered" Out-of-Plan.
- Coverage is provided in full for most preventive Services when those Services are received from specified In-Network Providers. See your Benefit Summary for additional information.
- 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 and our national In-Network Providers 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 3.5.**
- Coverage limitations and exclusions apply to certain Services, as stated in sections 3, 4, 5 and the Benefit Summary.
- 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 Plan documents. 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 or amendments that accompany these documents, the agreement between Providence Health Plan and the Plan Sponsor (if any), 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) Providence Health Plan/ Plan Sponsor agreement, (3) Summary Plan Description, (4) Benefit Summary(ies), and (5) applicable Providence Health Plan's policies.

1.2 GRANDFATHERED PLAN NOTICE

This Employer Group believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA). As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of PPACA that apply to other Plans, for example, the requirement for the coverage of certain preventive health care services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in PPACA, for example, the elimination of the lifetime maximum benefit.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the employer or human resources department.

Non-ERISA Plans: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

2. WELCOME TO PROVIDENCE HEALTH PLAN

Thank you for choosing Providence Health Plan. We look forward to meeting your health care needs. 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 Clackamas County Peace Officer Association Employees and their Dependents.

2.1 CLACKAMAS COUNTY PEACE OFFICERS ASSOCIATION OPEN OPTION GRANDFATHERED PLAN

Your Plan allows you to receive Covered Services from In-Network Providers through what is called your In-Plan benefit. You also have the option to receive most Covered Services from Out-of-Network Providers through what is called your Out-of-Plan 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 us to Prior Authorize treatment. If you receive Covered Services from Out-of-Network Providers, it is your responsibility to make sure the Services listed in section 3.5 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 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 for what you owe later. 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 Clackamas County. 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 15. 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:

- **Clackamas County Peace Officers Association Open Option Grandfathered Plan Medical Benefit Summary** and any other Benefit Summary documents issued with this Plan. These documents are available at ProvidenceHealthPlan.com when you register for a myProvidence account as explained in section 2.4. Benefit Summaries detail your Deductible, 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 or check with your Employer's human resource department to obtain a hard copy of the directory.

If you need 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.
- 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. 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. If you have questions or need assistance registering for or accessing an existing account, contact myProvidence customer service at 877.569.7768.

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 confer 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:

- Visit your health care provider or facility.
- Register online for your myProvidence account.
- Call for Mental Health/Substance Abuse 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 recorded message, a registered nurse will come on line to assist you.

Please have your Member ID Card available when you call.

2.7 WELLNESS BENEFITS

Providence Resource Line — 503-574-6595; 800-562-8964

Providence Resource Line is your connection to information and services on classes, self-help materials, tobacco-use cessation services, and for referrals to Providence Health Plan In-Network Providers and to Providence Health & Services programs and services. Services and health-education vary by geographic service area.

Health Education

Providence Health Plan offers a wide variety of classes to help you achieve healthy lifestyle and wellness goals. We can assist you in learning to eat right and manage your weight, prepare for childbirth and much more. If you have diabetes, health education classes also are available (see section 4.1.6, for further information).

Providence Health Plan Members receive discounts on health education classes. Your costs, services and the health education classes available may vary by geographic-service area. For more information on classes available in your area, call the Providence Resource Line at 503-574-6595 or 800-562-8964 or visit www.providence.org/classes.

Health Coaching
Providence Health Plan offers Members free coaching support for weight loss, diabetes prevention, nutrition, stress management, exercise, sleep and tobacco cessation. For more information on health coaching, call 503-574-6000 (TTY: 711) or 888-819-8999 or visit www.ProvidenceHealthPlan.com/healthcoach.

Care Management
Providence Care Management provides Members with information and assistance with healthcare navigation, as well as managing chronic conditions from a Registered Nurse Care Manager.

You can access these Services by calling 800-662-1121 or e-mailing caremanagement@providence.org.

Tobacco Use Cessation
Your Wellness Benefits include access to tobacco-use cessation programs provided through our Providence Health & Services Hospitals as well as through Quit for Life. These programs address tobacco dependence through a clinically proven, comprehensive approach to tobacco-use cessation that treats all three aspects of tobacco use – physical addiction, psychological dependence and behavioral patterns. (See section 4.1.8 regarding coverage for tobacco-use cessation Services).

More information about our Tobacco-Use Cessation programs can be found online at http://www.providence.org/healthplans/members/healthbalance/smokingcessation.aspx, or by calling 503-574-6595 or 800-562-8964.

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

Wellness information on our website — www.ProvidenceHealthPlan.com
Visit Providence Health Plan online at www.ProvidenceHealthPlan.com for medical information, class information, information on extra values and discounts and a wide array of other information described with your good health in mind. You also may set up your own myProvidence account to gain access to your specific personal health plan information. See Registering for a myProvidence account, section 2.4, for more details.

LifeBalance — 503-234-1375 or 888-754-LIFE www.LifeBalanceProgram.com
This program offers exclusive discounts to Providence Health Plan Members on a wide variety of health and wellness programs, as well as recreational, cultural and wellness activities. You can save on professional instruction, fitness club memberships, yoga classes, and much more. You also have access to discounted events, such as white-water rafting, ski trips, theater nights, and sporting events.

Learn more by visiting the LifeBalance website at www.LifeBalanceProgram.com or calling LifeBalance at 503-234-1375 or 888-754-LIFE. Please have your Providence Health Plan Member ID Card ready when you request LifeBalance discounts.

Assist America

Your wellness benefits include access to travel assistance services and identity theft protection services.

Travel Assistance Services include emergency logistical support to members traveling internationally or people traveling 100 miles from home. Learn more by visiting www.assistamerica.com or calling Assist America at 609-986-1234 or 800-872-1414.

Assist America also provides identity theft protection services 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. Please have your Providence Health Plan Member ID card ready, 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 https://healthplans.providence.org/members/rights-notices or by calling Customer Service.

Appointment of Authorized Representative

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

Confidentiality and your Employer

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

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

1. In compliance with the applicable provisions of HIPAA; and
2. Due to a HIPAA compliant authorization, the Member has completed to allow the Employer access to the Member's PHI; or
3. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer. The details of this required certification can be reviewed at https://healthplans.providence.org/about-us/privacy-notices-policies/protected-health-information-and-your-employer/.

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. HOW TO USE YOUR PLAN

Our goal is maintaining your health by promoting wellness and preventive care. We encourage you to work closely with one provider, your 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 section 4 of this Summary Plan Description.

3.1 IN-NETWORK PROVIDERS

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

For Services to be covered using your In-Plan 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.

3.1.1 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 of Oregon and southwest Washington.

3.1.2 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 the Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider. If you do not have access to our website, please call Customer Service to request In-Network Provider Information.

Advantages of 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 3.5.
- 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 an In-Network Primary Care Provider, whenever possible.

3.1.3 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 St., Ste. 800
Portland, OR 97209
Telephone: 503-414-5555

3.2 THE ROLE OF A PRIMARY CARE PROVIDER

To encourage optimum health, we promote wellness and preventive care. We also believe wellness and overall health is enhanced by working closely with one physician or provider – your 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 an In-Network Primary Care Provider as soon as possible.

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

3.2.2 Established Patients with Primary Care Providers

If you and your family already see a provider, you may want to check the provider directory to see if your provider is an In-Network Primary Care Provider for Providence Health Plan. If your provider is participating with us, let their office know you are now a Providence Health Plan Member.

3.2.3 Selecting a New Primary Care Provider

We recommend 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 they are 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.

3.2.4 Changing Your Primary Care Provider

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.

3.2.5 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 the Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider, or call Customer Service to choose a specialist who 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. (For certain Plans, there is a Member Copayment for specialist visits instead of a Coinsurance. If you are on one of these Plans, you will need to pay your Member Copayment at the time of your visit. Please check your Benefit Summary for your specific coverage information.)

Chiropractic Care Providers

This Plan includes coverage for specified chiropractic services. See section 4.15 and your Benefit Summary.

3.3 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-Plan benefit.

Benefits for Covered Services by an Out-of-Network Provider will be provided as shown in the Benefit Summary. See section 3.5 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.

IMPORTANT NOTE: Your Plan only pays for Covered Services received from Out-of-Network Providers at Usual, Customary, and Reasonable rates (UCR) (see Section 15, 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 Summary Plan Description. Your Plan will only pay for Medically Necessary Covered Services. No matter what type of provider you see, the treatments, supplies, and medications excluded by this Plan are not covered.

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

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

- Web-direct Visits (see section 4.3.2).
- E-mail Visits (see section 4.3.3).
- Temporomandibular Joint (TMJ) Services (see section 4.12.7).
- Tobacco Use Cessation Services (see section 4.1.8).
- Retail health Clinic Visits (see section 4.3.8).
- Human Organ/Tissue Transplants (see section 4.13).
- Any item listed in your Benefit Summary as "Not Covered" under Out-of-Plan.

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

After you meet your Deductible, if applicable, and if the Services provided are Medically Necessary Covered Services, we will provide payment to Out-of-Network Providers according to Usual, Customary and Reasonable (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 15 for the definition of UCR.

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

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

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

Payment for 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-Plan 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-Plan provider.

3.4 NOTICE OF PROVIDER TERMINATION

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

3.5 PRIOR AUTHORIZATION

While Prior Authorization is a requirement for coverage of certain Services under this Plan, Prior Authorization is not a treatment directive. The actual course of medical treatment that a Member chooses remains strictly a matter between the Member and the 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 Medical Necessity.

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. You or your Out-of-Network provider must contact us to obtain Prior Authorization. See section 3.3 for additional information about Out-of-Network Providers.

Services requiring Prior Authorization:

- All inpatient admissions to a Hospital (not including emergency room care), Skilled Nursing Facility or a rehabilitation facility, all emergency hospitalizations (we need to be notified within 48 hours, or as soon as reasonably possible), and all Hospital and birthing center admissions for maternity/delivery Services.
- All outpatient surgical procedures.
- Anesthesia Care with Diagnostic Endoscopy.
- All Travel Expense Reimbursement, as provided in section 3.6.
- All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services for Mental Health and Substance Abuse, as provided in sections 4.10.1 and 4.10.2.
- All Applied Behavior Analysis, as provided in section 4.10.3.
- All Human Organ/Tissue Transplant Services, as provided in section 4.13.
- All Restoration of Head/Facial Structures; Limited Dental Services, as provided in section 4.12.6.
- All Temporomandibular Joint (TMJ) Services, as provided in section 4.12.7.
- All High Tech Imaging, including PET, CT, CTA, MRI and MRA, Nuclear Cardiac Study Services, and echocardiography Services, as provided in section 4.4.1.
- All Sleep Study Services, as provided in section 4.4.2.
- Certain Home Health Care Services, as provided in section 4. 11.1.
- Certain Hospice Care Services, as provided in section 4.11.2.
- Certain Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment, as provided in section 4.9.

- Certain outpatient services including, but not limited to, neurodevelopmental therapy, neurological testing, and botulinum therapies.
- All outpatient hospitalization and anesthesia for dental Services, as provided in section 4.12.6.
- All Genetic Testing Services, as provided in section 4.12.1.
- Certain medications, including certain immunizations, received in your Provider's office as provided is sections 4.3.5 and 4.1.2.
- Certain prescription drugs specified in our Formulary, as provided in section 4.14.1.
- Certain infused Prescription Drugs administered in a hospital-based infusion center, as provided in section 4.7.1.

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-Plan 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 section 3.3, a 50% **penalty**, not to exceed $2,500 for each Covered Service, will be applied to the claim.

Should Providence Health Plan 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.

3.6 TRAVEL EXPENSE REIMBURSEMENT

Subject to Prior Authorization, if you are unable to locate an In-Network Provider to provide Medically Necessary Covered Services for your specific condition within 50 miles of your home, the Plan will reimburse your travel expense to the nearest In-Network Provider within 300 miles of your home. Reimbursement will be based on the federal medical mileage reimbursement rate in effect on the date of service. Travel expense reimbursement is limited to $1,500 per calendar year. If an overnight stay is required, food and lodging are reimbursable up to $150 per diem (per day). Per diem expenses apply to the $1,500 travel expenses reimbursement maximum. (Note: Transplant Covered Services include a separate travel expense benefit; see section 4.13.1).

3.7 MEDICAL COST MANAGEMENT

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

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 Services 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.

3.7.1 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 7.

3.8 MEDICALLY NECESSARY SERVICES

We believe our Members are entitled to comprehensive medical care within the standards of good medical practice. Providence Health Plan's medical directors and special committees of In-Network Providers determine which Services are Medically Necessary, as defined in

section 15. 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 our guidelines. Obtaining confirmation of coverage from Providence Health Plan beforehand is always recommended.

3.9 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, the Plan 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.

3.10 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.

3.11 DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS

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

3.11.1 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 us. Deductible amounts are payable to your Qualified Practitioner after we have processed your claim.

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

***Common In-Plan and Out-of-Plan Deductible*:** Your Plan has a **Common Deductible**, as listed in your Benefit Summary. **A Common Deductible applies to both In-Plan and Out-of-Plan benefits**. The Common Deductible can be met by using In-Plan or Out-of-Plan benefits, or a combination of both.

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

***Family Deductible*:** The Family Deductible is the amount shown in the Benefit Summary that applies when three or more Family Members are enrolled in this Plan, and is the maximum Deductible 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.

3.11.2 Understanding Out-of-Pocket Maximums

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

***Common In-Plan and Out-of-Plan Out-of-Pocket Maximums*:** Your Plan has a Common In-Plan and Out-of-Plan Out-of-Pocket Maximum, as listed in your Benefit Summary. The Common Out-of-Pocket Maximum can be met by payments you make for Covered Services using In-Plan and Out-of-Plan benefits.

***Individual Out-of-Pocket Maximum*:** Individual Out-of-Pocket Maximum means the total amount of Copayments and Coinsurance that a Member must pay in a Calendar Year, as shown in the Benefit Summary, before the Plan begins to pay 100% for Covered Services for that Member within that Calendar Year.

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

Note: Once any 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 by this Plan;
- Services not covered because Prior Authorization was not obtained, as required in section 3.5;
- 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; and
- Any penalties you must pay if you do not follow 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. COVERED SERVICES

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

Please refer to your Benefit Summary for details of your specific coverage. You can view your Member materials by registering for a myProvidence account on our website at www.ProvidenceHealthPlan.com (see section 2.4). If Clackamas County modifies your benefits, you will be notified in writing of the changes.

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

4.1 PREVENTIVE SERVICES

Preventive Services are covered as shown in the Benefit Summary. For Women's Preventive Health Care Services, see section4.2.
In accordance with the Patient Protection and Affordable Care Act of 2010 and related legislation, your Plan covers the following Services in full when received from In-Network Providers:

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

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

4.1.1 Physical Examinations and Well-Baby Care

Periodic health exams and well-baby care Services are covered only when received from an In-Network Primary Care Provider. These services are covered as stated in your Benefit Summary. Your provider will determine which tests are necessary for your physical exam according to your medical history and your current health status. More frequent exams will be covered if your provider determines that they are necessary. Vision and hearing screening services are covered when performed during a periodic health examination or well-baby care examination. In order for a child to be eligible for benefits for routine newborn baby care, the child must be properly enrolled as outlined in section 8. Ancillary Services, such as immunizations, are covered at the specified benefit level when billed by the provider.

Recommended Guidelines:

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. The Plan will not cover this additional fee.

Covered Services do **NOT** include the following:

1. Services for laser surgery, radial keratotomy and any other surgery to correct myopia, hyperopia or stigmatic error, vision therapy, orthoptic treatment (eye exercises);
2. Services for routine eye and vision care, refractive disorders, eyeglass frames and lenses, contact lenses; and
3. Hearing aids, except as specified in section 4.12.11.

4.1.2 Immunizations and Vaccinations

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

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

4.1.3 Prostate Cancer Screening Exams

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

4.1.4 Colorectal Cancer Screening Exams

Benefits for colorectal cancer screening examinations for Members age 50 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 high risk are covered as recommended by the Qualified Practitioner.

For Members age 50 and older:

- In-Plan: All Services for colorectal cancer screenings and exams are covered in full.
- Out-of-Plan: 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 50:

- In-Plan and Out-of-Plan: 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.

4.1.5 Preventive Services for Members with Diabetes

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

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

4.1.6 Diabetes Self-Management Education Program

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

4.1.7 Nutritional Counseling

A maximum of two visits per Calendar Year are covered for nutritional counseling when Medically Necessary, as determined by the Qualified Practitioner. Fasting and rapid weight loss programs are not covered.

4.1.8 Tobacco Use Cessation Services

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

4.2 WOMEN'S PREVENTIVE HEALTH CARE SERVICES

Women may choose to receive Women's Preventive Health Care Services from a Primary Care Provider or a Women's Health Care Provider. Women's Health Care Providers include physicians specializing in obstetrics, some Primary Care Providers (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.

4.2.1 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 4.2.4). Benefits also include follow-up exams for any medical conditions discovered during an Annual gynecological exam that require additional treatment.

4.2.2 Mammograms

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

4.2.3 Breastfeeding Counseling and Support

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

4.2.4 Family Planning Services

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

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

- Intrauterine device (IUD) insertion and removal;
- Medical exams and consultation for family planning;
- Depo-Provera to prevent pregnancy;
- Diaphragm devices;
- Removal of implantable contraceptives; and
- Oral contraceptives (birth control pills) listed in our Formulary. FDA-approved women's prescription contraceptives: up to 3 months initial dispensing, then up to 12 months subsequent dispensing at any Participating Pharmacy.

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

- In-Plan: Services are covered in full.
- Out-of-Plan: Services are covered subject to the provisions of the applicable In-Plan or Out-of-Plan benefit, e.g. IUDs and diaphragms are covered under your medical supply benefit.

For coverage of tubal ligation, see Elective Sterilization, section 4.12.10.

4.3 PROVIDER SERVICES

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

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

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

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

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

4.3.2 Virtual Visits

The Plan provides coverage for Virtual Visits using secure internet technology:

- Phone and Video Visits: Phone and Video Visits are covered as shown in your Benefit Summary. All Phone and Video Visits must be Medically Necessary and may be received from authorized In-Network or Out-of-Network Providers. Not all Providers are contracted with us to provide Phone and Video Visits. Providers who are authorized to provide Phone and Video Visits have agreed to use secure internet technology approved by us to protect your information from unauthorized access or release.

4.3.3 E-mail Visits

E-mail Visits are covered in full and must be received from In-Network Providers. Not all In-Network Providers offer E-mail Visits. Medical doctors (M.D.), doctors of osteopathy (D.O.), nurse practitioners (N.P.) and physician assistants (P.A.) are the only categories of providers 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 the Plan;
- 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 Abuse Covered Services (as provided in section 4.10).

4.3.4 Telemedical Services

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

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

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

4.3.5 Allergy Shots, Allergy Serums, Injectable and Infused Medications

Allergy shots, allergy serum, injectable medications, and total parenteral nutrition (TPN) received in your Provider's office are covered as shown in your Benefit Summary. Therapy and testing for treatment of allergies including, but not limited to, Services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment are covered only when such therapy or testing is approved by the American Academy of Allergy and Immunology, or the Department of Health and Human Services or any of its offices or agencies. Some injectable medications may require Prior Authorization, as listed in the Medical benefit drug prior authorization list available on our website at https://healthplans.providence.org/members/pharmacy-resources/Pages/default.aspx or by calling Customer Service. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. See section 4.7.1 for coverage of infusion at Outpatient Facilities.

4.3.6 Administration of Anesthesia and Surgical Procedures

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

4.3.7 Immediate Care

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

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

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

4.3.8 Retail Health Clinic

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

4.4 DIAGNOSTIC SERVICES

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

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

Benefits are as shown in the Benefit Summary and include inpatient and outpatient diagnostic pathology (lab), high tech imaging (such as PET, CT, MRI and MRA), radiology (X-ray) tests, echocardiography, and other Medically Necessary diagnostic procedures. Covered Services include contrast materials (dyes) that may be required for a diagnostic procedure.

4.4.2 Sleep Study Services

Benefits include coverage of Medically Necessary polysomnography (PSG). PSG is an overnight sleep test performed at home or in a sleep laboratory. The test is used to confirm a sleep disorder and to determine the appropriate treatment. Services must be Prior Authorized.

The following diagnostics are excluded: actigraphy, daytime nap polysomnography, cephalographic or tomographic X-rays for diagnosis or evaluation of an oral device, and acoustic pharyngometry.

4.5 EMERGENCY CARE AND URGENT CARE SERVICES

Benefits for Emergency Services and Urgent Care Services are provided as described below and shown in your Benefit Summary. Emergency Care Services are provided both in and out of the Service Area. If an emergency situation should occur, you should take immediate action and seek prompt medical care. You should call 911, or the emergency number listed in the local telephone directory or go to the nearest Hospital emergency department.

4.5.1 Emergency Care

A medical emergency is a sudden unexpected illness or injury that you believe would place your life in danger or cause serious damage to your health if you do not seek immediate medical treatment. Medical emergencies include, but are not limited to:

- Heart attack
- Stroke
- Poisoning
- Loss of consciousness
- Medically necessary detoxification
- Acute abdominal pain
- Severe chest pain
- Serious burn
- Bleeding that does not stop
- Unexpected premature childbirth

Coverage is provided without Prior Authorization for Emergency Medical Screening Exams and stabilization of an Emergency Medical Condition. Hospitalization for an Emergency Medical Condition requires notification to Providence Health Plan within 48 hours, or as soon as reasonably possible following the onset of treatment, in order for coverage to continue.

Definitions:

"Emergency Medical Condition" is a medical condition that manifests itself by acute symptoms of sufficient severity that a prudent layperson, possessing an average knowledge of health and medicine, would reasonably expect that failure to receive immediate medical attention would:

- Result in serious impairment to bodily functions;
- Result in serious dysfunction of any bodily organ or part; or
- 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.

"Emergency Services" means, with respect to an Emergency Medical Condition:

- An Emergency Medical Screening Exam that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
- Such further medical examination and treatment as are required under the Emergency Medical Treatment and Active Labor Act (42 U.S.C. 1395dd) to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at the Hospital.

"Emergency Medical Screening Exams" include medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.

Your Plan covers Emergency Services in the emergency room of any Hospital. **Emergency room Services are covered when your medical condition meets the guidelines for emergency care as stated above. Coverage includes Services to stabilize an Emergency Medical Condition and Emergency Medical Screening Exams.**

If you or a Family Member believes that immediate assistance is needed for an Emergency Medical Condition, **call 911 or go to the nearest emergency room**. Tell the emergency personnel the name of your Primary Care Provider and show them your Member ID Card.

Call your Primary Care Provider any time, any day of the week. Your Primary Care Provider or the provider-on-call will tell you what to do and where to go for the most appropriate care.

Please be prepared to pay your Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are responsible for the Copayment/Coinsurance for each Hospital emergency room visit. If you are admitted to the Hospital from the emergency room, your emergency Services Copayment/Coinsurance does not apply and all Services are subject to the Inpatient Services benefit shown in your Benefit Summary.

When you are admitted to an Out-of-Network Hospital from the emergency room, your Inpatient Services are covered under your In-Network benefit until your condition becomes stable. Once your condition is stabilized, Providence Health Plan will work with you to arrange transfer to an In-Network facility. This process is called "repatriation."

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.

Note: While Emergency Services received from Out-of-Network Providers at Out-of-Network Facilities are covered under your In-Patient benefit until the time that your condition

becomes stable, the Out-of-Network Providers and Out-of-Network Facilities are not contracted with Providence Health Plan. Therefore, the claims are priced using Usual, Reasonable and Customary (UCR) pricing, as described in section 3.3. Unless otherwise prohibited by state or federal law, you may be billed by the Out-of-Network Providers and Out-of-Network Facilities for amounts above the Allowed Amount of the claim, as determined by UCR.

Costs for non-emergency medical transport to facilitate repatriation to an In-Network facility are covered in full.

The Plan does not pay for emergency room treatment for medical conditions that are not medical emergencies. Do not go to the emergency room for care that should take place in your provider's office. Routine care for sore throats, common colds, follow-up care, and prescription drug requests are not considered to be emergencies.

4.5.2 Emergency Medical Transportation

Benefits include Services for emergency medical transportation by state certified ambulance and certified air ambulance transportation. Ambulance Services are provided for transportation to the nearest facility capable of providing the necessary emergency care or to a facility specified by Providence Health Plan. Air ambulance transportation is only covered for a life-threatening medical emergency, or when ground ambulance is either not available or would cause an unreasonable risk of harm because of increased travel time. Ambulance transportation solely for personal comfort or convenience is not covered.

4.5.3 Emergency Eye Care Services

Covered Services include the initial care for Emergency Medical Conditions 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.

4.5.4 Emergency Detoxification Services

Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a Substance Abuse treatment program, as stated in section 4.10.3, 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. Continuing or follow-up care is not a Covered Service unless Prior Authorized by Providence Health Plan.

4.5.5 Urgent Care

Urgent Care is treatment you need right away for an illness or injury that is not life threatening. This includes, but is not limited to, minor sprains, minor cuts and burns, and ear, nose, and throat infections. Routine care that can be delayed until you can be seen by a physician or provider in their 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. They may either suggest that you come to the office or go to an emergency room or Urgent Care center. If you can be

treated in your provider's office or at an In-Network Urgent Care center your out-of-pocket expense will usually be lower.

Please be prepared to pay the Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are also responsible for the applicable Copayment/Coinsurance shown in the Benefit Summary for any ancillary Services received, such as lab tests and X-rays, billed by the Qualified Provider.

If you are admitted to an Out-of-Network Hospital, you, or a relative, should call Providence Health Plan within 48 hours or as soon as reasonably possible.

When you are admitted to an Out-of-Network Hospital from an Urgent Care facility, your Inpatient Services are covered under your In-Network benefit until your condition becomes stable. Once your condition is stabilized, Providence Health Plan will work with you to arrange transfer to an In-Network facility. This process is called "repatriation."

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.

Costs for non-emergency medical transport to facilitate repatriation to an In-Network facility are covered in full.

Not all Out-of-Network facilities will file a claim on a Member's behalf. If you receive urgent care Services from an Out-of-Network facility, you must submit a claim if the facility or provider does not submit it for you. See section 6.1.1.

4.6 INPATIENT HOSPITAL AND SKILLED NURSING FACILITY SERVICES

Coverage is provided as shown in your Benefit Summary for Hospital and Skilled Nursing Facility Services.

Covered Services do NOT include care received that consists primarily of:

- Room and board and supervisory or custodial Services.
- Personal hygiene and other forms of self-care.
- Non-skilled care for senile deterioration, mental deficiency, or developmental disability.

In all cases, the following are specifically excluded from the Hospital and Skilled Nursing Facility benefit:

- Private duty nursing or a private room unless prescribed as Medically Necessary or otherwise Prior Authorized.
- Take-home medications, supplies and equipment.
- Personal items such as telephone, radio, television and guest meals.

4.6.1 Inpatient Hospital Services

Benefits are provided as shown in your Benefit Summary.

In-Plan Benefit: When your In-Network Provider and Providence Health Plan determine you

need hospitalization, arrangements will be made for you to be admitted to an In-Network Hospital.

Out-of-Plan 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; and
- Hospital services and supplies necessary for treatment and furnished by the Hospital, such as use of the operating and recovery rooms, anesthesia, dressings, medications, whole blood and blood products, oxygen, X-ray, and laboratory Services during the period of inpatient hospitalization. (Personal items such as guest meals, slippers, etc., are not covered.)

Providence Health Plan employs professional clinical staff who may review services you receive in the Hospital. They may review your care to determine Medical Necessity, to make sure that you had quality care, and to ensure that you will have proper follow-up care.

Your provider will determine your medically appropriate length of stay. If you choose to stay in the Hospital longer than your physician advises, you will be responsible for the cost of additional days in the Hospital.

4.6.2 Skilled Nursing Facility

Benefits are provided as shown in the Benefit Summary for Covered Services from a Skilled Nursing Facility. Services must be Prior Authorized by Providence Health Plan and prescribed by your Qualified Practitioner in order to limit Hospital Confinement by providing convalescent skilled medical and nursing Services which cannot be adequately provided through a home health program. Benefits are subject to the durational limits stated in your Benefit Summary.

4.6.3 Inpatient Rehabilitative Care

Benefits are provided for physical, occupational and speech therapy Covered Services as shown in the Benefit Summary for inpatient rehabilitative care to restore or improve lost function following illness or injury. If a Member is hospitalized when rehabilitative Services begin, rehabilitation benefits will begin on the day treatment becomes primarily rehabilitative. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition. Benefits are subject to the durational limits stated in the Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 4.7.2 for coverage of Outpatient Rehabilitative Services.)

4.6.4 Inpatient Habilitative Care

Coverage is provided 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 4.7.3 for coverage of Outpatient Habilitative Services.)

4.6.5 Observation Care

Benefits are provided, as shown in the Benefit Summary, for Covered Services provided by the Hospital or the Qualified Practitioner while you are held in the Hospital for observation. Observation care includes the use of a bed and periodic monitoring which are reasonable and necessary to evaluate your condition as an outpatient or determine the need for possible admission to the hospital as an inpatient. In general, the duration of observation care does not exceed 24 - 48 hours. Observation care for greater than 48 hours without inpatient admission is generally considered not Medically Necessary and may be subject to medical review.

4.7 OUTPATIENT SERVICES

4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy, and Multidisciplinary Pain Management Programs

Benefits are provided as shown in the Benefit Summary and include Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, 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. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. The Plan may require that you obtain a second opinion for some 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 3.5.

Covered Services under these benefits do not include Services for Outpatient Rehabilitative Services. See section 4.7.2 for those Services.

4.7.2 Outpatient Rehabilitative Services

Benefits are included for outpatient physical, occupational and speech therapy Covered Services provided by a physician or licensed/registered therapist, as stated in the Benefit Summary, to restore or improve lost function following illness or injury.

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 Covered Services. (See section 4.6.3 for coverage of Inpatient Rehabilitative Services.) All Services are subject to review for Medical Necessity.

Covered Services under this benefit do NOT include:

- Chiropractic adjustments and manipulations of any spinal or bodily area;
- Exercise programs;
- Rolfing, polarity therapy and similar therapies; and
- Rehabilitation services provided under an authorized home health care plan as stated in section 4.11.

4.7.3 Outpatient Habilitative Services

Coverage is provided, as stated in the Benefit Summary, for Medically Necessary outpatient habilitative Services for maintenance, learning or improving skills and function for daily living. 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 4.6.4 for coverage of Inpatient Habilitative Services.)

4.8 MATERNITY SERVICES

Your benefits include coverage for comprehensive maternity care.

Your Benefit Summary lists your Member costs (Deductible, Copayment and/or Coinsurance) per pregnancy for prenatal office visits, postnatal office visits, and delivery Provider Services. These Member costs do not apply to other Covered Services, such as lab and imaging, which you may receive for your maternity care. The specific Coinsurance or Copayment for each of these services will apply instead. Please refer to your Benefit Summary for details.

Women may choose to receive Maternity Services from a Primary Care Provider or a Women's Health Care Provider. Women's Health Care Providers include physicians specializing in obstetrics, some Primary Care Providers (if they are licensed to provide obstetrical services), physician assistants and advanced registered nurse practitioners specializing in women's health care, certified nurse midwives, and licensed direct entry midwives.

<u>Covered Services include:</u>

- Prenatal care.
- Delivery at an approved facility or birthing center.
- Postnatal care, including complications of pregnancy and delivery.
- Emergency treatment for complications of pregnancy and unexpected pre-term birth.
- Newborn nursery care*.
- Newborn nurse home visits**.

*Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit.

**Newborn nurse home visits are provided for newborns up to 6 months of age, including foster and newly adopted newborns, for Oregon members residing in a community where the Oregon Health Authority (OHA) Universal Newborn Nurse Home Visiting Program is operating. Newborn nurse home visits are covered without member cost-share (unless required for the Plan to maintain HSA-qualified status) under the newborn's In-Network benefits and must be received from nurses certified by OHA to provide the services.

PLEASE NOTE: Newborn nursery care, newborn nurse home visits, and any other Services provided to your newborn are covered only when the newborn child is properly enrolled under this Plan within time frames outlined in Newborn Eligibility and Enrollment, section 8.2.4.

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.

Length of maternity hospital stay: Your services include a hospital stay of a minimum of 48 hours for a normal vaginal delivery, and a minimum of 96 hours for a Caesarean delivery. You will not be discharged from the hospital sooner than these guidelines, unless you choose to be. You and your physician/provider will determine the length of your hospital stay and follow-up care based on accepted medical practice.

Maternity support services: Members may attend a class to prepare for childbirth. The classes are held at In-Network Hospitals. Call the Providence Resource Line at 503-574-6595 or visit www.providence.org/classes for information on classes, specific dates, locations, registration and prices. Classes vary by geographic area. In addition, Members with high-risk pregnancies may receive support services through care or case management. A care manager may be a social worker or a registered nurse.

Diabetes coverage during pregnancy: During pregnancy through six weeks postpartum, the Plan provides coverage in full for diabetes services, medications, and supplies when received In-Plan.

4.9 MEDICAL SUPPLIES, MEDICAL APPLIANCES, PROSTHETIC AND ORTHOTIC DEVICES AND DURABLE MEDICAL EQUIPMENT (DME)

Benefits for medical supplies, medical appliances, prosthetic and orthotic devices and Durable Medical Equipment (DME) are provided as shown in the Benefit Summary when required for the standard treatment of illness of 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.

4.9.1 Medical Supplies (including Diabetes Supplies)

Benefits are shown in the Benefit Summary for the following medical supplies and diabetes supplies:

1. Medically Necessary supplies as ordered by your Qualified Practitioner, including, but not limited to, ostomy supplies, prescribed needles, syringes and chem strips. Non-sterile examination gloves used by you or your caregiver are NOT a covered medical supply.
2. Diabetes supplies, such as needles, syringes, continuous glucose monitors and blood glucose monitors, lancets and test strips, may be purchased through Providence Health Plan In-Network medical supply providers at Participating Pharmacies. Formulary, Prior Authorization, and quantity limits may apply – please see your Formulary for details. See section 4.9.4 for coverage of diabetic equipment such as insulin pump devices.
3. Medically Necessary medical foods for supplementation or dietary replacement including non-prescription elemental enteral formula for home use, when determined to be Medically Necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition. Medical foods are also covered for the treatment of Inborn Errors of Metabolism, as described in section 4.12.2. Medical foods do not include total parenteral nutrition (TPN), which is covered under section 4.3.5.

4.9.2 Medical Appliances

Benefits are provided as shown in the Benefit Summary for the following medical appliances:

1. Casts, braces and supportive devices when used in the treatment of medical or surgical conditions in acute or convalescent stages or as immediate post-surgical care.
2. Initial and replacement contact lenses, intraocular lenses, prescription lenses or standard frame glasses, when required as a result of injury, illness or surgery, such as, but not limited to, cataract, corneal transplant surgery or for the treatment of keratoconus.
3. Rental of an oxygen unit used in the home for Members with significant hypoxemia who are unresponsive to other forms of treatment. The benefit is limited to three months from the initial date of Service unless there is clinical evidence of the need to continue.
4. Removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are subject to the benefit maximum stated in the Benefit Summary, 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 Assisted Technology (HAT) as ordered by your Qualified Practitioner.

4.9.3 Prosthetic and Orthotic Devices

Benefits are provided for prosthetic and orthotic devices as shown in the Benefit Summary. Coverage is limited to those prosthetic and orthotic devices that are Medically Necessary and included in the Medicare fee schedule for Durable Medical Equipment, Prosthetics, Orthotics and Supplies. Covered Services include rigid or semi-rigid devices used for supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck; or an artificial limb device or appliance designed to replace in whole or in part an arm or a leg; breast implants following mastectomy; artificial eyes; and maxillofacial prosthetic devices for the restoration and management of head and facial structures. (For coverage of removable custom shoe orthotics, see section 4.9.2).

4.9.4 Durable Medical Equipment (DME)

Benefits are provided for DME as shown in the Benefit Summary. Covered Services may include Medically Necessary equipment such as a hospital bed, non-motorized wheelchair, ventilator, and similar equipment as approved by 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).

4.10 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

This Plan complies with Oregon and Federal Mental Health Parity.

4.10.1 Mental Health Services

Benefits are provided for Mental Health Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions.

Covered Services include diagnostic evaluation, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services. All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services must be Prior Authorized as specified in section 3.5.

In an emergency situation, go directly to a Hospital emergency room. You do not need Prior Authorization for emergency treatment; however, Providence Health Plan must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue.

4.10.2 Applied Behavior Analysis

Benefits are provided for Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorders, subject to the following limitations:

- Services must be Medically Necessary;
- The initial screening and an individualized treatment plan must be provided by a licensed neurologist, pediatric neurologist, developmental pediatrician, psychiatrist or

psychologist, who has experience or training the diagnosis of autism spectrum disorder;
- Prior authorization is received by us;
- Benefits include coverage of any other non-excluded mental health or medical services identified in the individualize treatment plan;
- Treatment must be provided by a health care professional licensed to provide ABA Services; and
- Treatment may be provided in the Member's home or in a licensed health care facility.

Exclusions to ABA Services:
- Services provided by a family or household member;
- Services that are custodial in nature, or that constitute marital, family, or training services;
- Services that are educational or correctional that are provided by a school or halfway house or received as part of an education or training program;
- Custodial or respite care, equine assisted therapy, creative arts therapy, wilderness or adventure camps, social counseling, telemedicine, music therapy, chelation or hyperbaric chambers;
- Services provided under an individual education plan in accordance with the Individuals with Disabilities Education Act;
- Services provided through community or social programs; and
- Services provided by the Department of Human Services or the Oregon Health authority, other than employee benefit plans offered by the department and the authority.

An approved ABA treatment plan is subject to review by us, and may be modified or discontinued if review shows that the Member receiving treatment is not making measurable clinical progress toward the goals identified in the treatment plan.

4.10.3 Substance Abuse Services

Benefits are provided for Substance Abuse Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions.

Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan.

Prior Authorization is required for all inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services, as specified in section 3.5.

Treatments involving the use of methadone are a Covered Service only when such treatment is part of a medically-supervised treatment program that has been Prior Authorized.

In an emergency situation, go directly to a Hospital emergency room. You do not need Prior Authorization for emergency treatment; however, 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.

4.11 HOME HEALTH AND HOSPICE CARE

4.11.1 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.

Any visit by a person providing Services under a home health care plan, or evaluating the need for or developing a plan is considered one home health care visit. Up to four consecutive hours in a 24-hour period of home health care Service is considered one home health care visit. A home health care visit of more than four hours is considered one visit for every four hours or part thereof.

Home health care will not be reimbursed unless your Qualified Practitioner certifies that the home health care Services will be provided or coordinated by a state-licensed or Medicare-certified Home Health 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;
3. Charges for supervision of Home Health Providers; or
4. Services that consist principally of Custodial Care including, but not limited to, care for senile deterioration, mental deficiency, mental illness, developmental disability or care of a chronic or congenital condition on a long-term basis.

4.11.2 Hospice Care

Benefits are included for hospice care as shown in the Benefit Summary and as stated in this section. In addition, the following criteria must be met:

1. Your Qualified Practitioner certifies that you have a terminal illness with a life expectancy not exceeding six months; and
2. The Covered Services provided are reasonable and necessary for the condition and symptoms being treated.

When the above criteria are met, the Plan will provide benefits for a full range of Covered Services which a certified hospice care program is required to include. Covered Services

include the following:

- Nursing care provided by or under the supervision of a registered nurse;
- Medical social services provided by a medical social worker who is working under the direction of a physician, including counseling for the purpose of helping you and your caregivers adjust to the approaching death;
- Services provided by your Qualified Practitioner or a physician associated with the hospice program;
- Durable Medical Equipment, medical supplies and devices, including medications used primarily for the relief of pain and control of symptoms related to the terminal illness;
- Home health aide Services for personal care, maintenance of a safe and healthy environment and general support to the goals of the plan of care;
- Rehabilitation therapies provided for purposes of symptom control or to enable you to maintain activities of daily living and basic functional skills; and
- Continuous home care during a period of crisis in which you require skilled intervention to achieve palliation or management of acute medical symptoms.

Respite care is not covered.

4.12 OTHER COVERED SERVICES

4.12.1 Genetic Testing and Counseling Services

Genetic testing and counseling are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature. Genetic testing requires Prior Authorization as shown in section 3.5.

All Direct-to-Consumer genetic tests are considered investigational and are not covered.

4.12.2 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 4.9.1.

4.12.3 Podiatry/Foot Services

Benefits include Covered Services of a podiatrist or other Qualified Practitioner and are provided as shown in the Physician/Provider Services section of the Benefit Summary. Covered Services include, but are not limited to, the fitting and follow up exam for removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are covered as stated in section 4.9.2 (Medical Appliances). Covered Services do not include routine foot care and the removal of corns or calluses, unless you have diabetes.

4.12.4 Reconstructive Surgery

Reconstructive Surgery is covered for conditions resulting from congenital defects, developmental abnormalities, trauma, infection, tumors or disease. Reconstructive surgery may be performed to correct a functional impairment in which the special, normal or proper action of any body part or organ is damaged; when necessary because of accidental injury or to correct scars or defects from accidental injury; or when necessary to correct scars or defects to the head or neck resulting from covered surgery. Benefits are covered as those Services listed in the Benefit Summary based upon the type of Services received. For Restoration of Head or Facial Structures; Limited Dental Services, see section 4.12.6.

4.12.5 Reconstructive Breast Surgery

Members who have undergone mastectomy are entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). "Mastectomy" means the surgical removal of breast tissue and breast lumps due to malignancy or suspected malignancy.

Benefits for Reconstructive Surgery of the breast are covered as those Services listed in the Benefit Summary based upon the type of Services received. Reconstructive Surgery of the breast is covered for:

- Reconstruction of the involved breast following a mastectomy;
- Surgery and construction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

If you have additional questions about your WHCRA benefits, please contact Customer Service.

4.12.6 Restoration of Head/Facial Structures; Limited Dental Services

Covered Services are limited to those Services that are Medically Necessary for the purpose of controlling or eliminating infection, controlling or eliminating pain, or restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic services to improve on the normal range of conditions. Medically Necessary Covered Services include restoration and management of head and facial structures, including teeth, dental implants and bridges, that cannot be replaced with living tissue and that are defective because of trauma, disease or birth or developmental deformities, not including overbite, crossbite, malocclusion or similar developmental irregularities of the teeth or jaw.

Benefits are covered as those Services listed in the Benefit Summary based upon the type of Services received.

Exclusions that apply to Covered Services include:

- Cosmetic Services;
- Services rendered to improve a condition that falls within the normal range of such conditions;
- Routine Orthodontia;
- Services to treat tooth decay, periodontal conditions and deficiencies in dental hygiene;

- Removal of impacted teeth;
- The making or repairing of dentures;
- Orthognathic surgery to treat developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth; and
- Services to treat temporomandibular joint syndrome, including orthognathic surgery, except as provided in 4.12.7.

Outpatient Hospitalization and Anesthesia for Limited Dental Services

Benefits for outpatient hospitalization and anesthesia for dental Services are covered as those Services listed in the Benefit Summary based upon the type of Services received and will only be provided for Members with complicating medical conditions. Examples of these conditions include, but are not limited to:

- Developmental disabilities;
- Physical disabilities; or
- A combination of medical conditions or disabilities which cannot be managed safely and efficiently in a dental office.

Dental Services are excluded.

4.12.7 Temporomandibular Joint (TMJ) Services

Benefits are provided for TMJ Services from an In-Network Provider 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 4.9.2(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-Plan benefits do not apply to TMJ Services.

Covered Services for TMJ conditions do not include dental or orthodontia Services.

4.12.8 Self-Administered Chemotherapy

Self-administered chemotherapy agents, including oral medications and injectable medications, are covered under your Prescription Drug benefit when received from a Participating retail or specialty Pharmacy as shown in the Benefit Summary (See section 4.14).

4.12.9 Gender Dysphoria

Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for a list of services requiring Prior Authorization.

4.12.10 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-Plan: Services are covered in full.
- Out-of-Plan: Services are covered subject to the provisions of the applicable Out-of-Plan 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.

4.12.11 Hearing Loss Services

Definitions:

Cochlear Implant

Cochlear Implant means a device that can be surgically implanted under the skin in the bony area behind the ear (the cochlea) to stimulate hearing.

Hearing Aid

Hearing Aid means any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments, batteries or accessory for the instrument or device, except cords.

Covered Services:

The following hearing loss services are covered under this Plan as described below. Benefits for such services are provided at the applicable benefit level for that particular type of service, as listed in your Benefit Summary.

All Covered Services must be Medically Necessary and appropriate, and prescribed, fitted, and dispensed by a licensed audiologist, hearing aid/instrument specialist, or other Qualified Practitioner.

Cochlear implants:

Cochlear implants for one or both ears, including programming, reprogramming, replacement and repair expenses. Cochlear Implants require Prior Authorization. The devices are covered under the Surgery and applicable Facility benefit.

Hearing aids & related accessories:

Medically Necessary external hearing aids and devices, as prescribed, fitted, and dispensed by a licensed audiologist or a hearing aid/instrument specialist. Hearing aids and devices are covered under the Medical Appliances benefit. This benefit is available for one hearing aid per ear every three Calendar Years for all Members. Hearing aid batteries are covered for one box per hearing aid per Calendar Year.

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.

Hearing Assistance Technology:

- Bone conduction sound processors, if necessary for appropriate amplification of hearing loss. This benefit is available once every three Calendar Years for all Members.
- Hearing assistive technology systems, if necessary, for appropriate amplification of hearing loss. This benefit is available once every three Calendar Years for all Members.

Limits to Hearing Loss Services

Coverage for hearing loss services are provided in accordance with state and federal law.

4.12.12 Wigs

The Plan will provide coverage for one synthetic wig every calendar year for Members who have undergone chemotherapy or radiation therapy or are experiencing pharmaceutical drug-induced Alopecia at the Medical Equipment, Supplies and Devices benefit level listed in your Benefit Summary. Wigs may be purchased from any wig supplier. Wig suppliers may require Members to pay for items and submit the paid receipt to Providence Health Plan for reimbursement. For information about submitting claims, see section 6.1.1.

4.13 HUMAN ORGAN/TISSUE TRANSPLANTS

A transplant is defined as a procedure or series of procedures by which an organ or tissue is either:

- Removed from the body of one person (the donor) and implanted in the body of another person (the recipient who is a Member); or
- Removed from and replaced in the same person's body (a self-donor who is a Member).

The term transplant does not include Services related to the transfusion of blood or blood derivatives (except hematopoietic stem cells) or replacement of a cornea. Corneal replacement is covered under the applicable provider and facility surgical benefits.

4.13.1 Covered Services

Covered Services for transplants are limited to Services that:

1. Are determined by Providence Health Plan to be Medically Necessary and medically appropriate according to national standards of care;
2. Are provided at a facility approved by us or under contract with Providence Health Plan (the Out-of-Plan 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 lifetime benefit maximum for transportation, food and lodging. Food and lodging is subject to a $150 per diem. Per diem expenses apply to the $5,000 travel expenses lifetime 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.

4.13.2 Benefits for Transplant Facility Services Provided to the Organ Recipient

The Member/recipient is responsible for the Coinsurance or Copayment amounts for pre-transplant services and post-transplant services at the applicable Inpatient Hospital Services and Outpatient Facility Services benefit.

The transplant procedure and related inpatient services are billed at a Global Fee. The Global Fee can include facility, professional, organ acquisition, and inpatient day charges. It does not include pre-transplant and post-transplant services. The Member/recipient is responsible for the Deductible, Coinsurance or Copayment amounts for the Global Fee at the applicable Inpatient Hospital Service benefit.

The Global Fee and the pre-transplant and post-transplant Services will apply to the Member's Out-of-Pocket Maximum.

4.13.3 Benefits for Outpatient Medications

Outpatient prescription medications for transplant-related Services, including anti-rejection (immunosuppressive) drugs, are not eligible for reimbursement under the medical benefits of this Plan. Benefits for outpatient prescription drugs are provided under this Plan's Prescription Drug Benefit and those benefits are subject to the terms and limitations of that Benefit.

4.13.4 Benefits for Physician/Provider Services Provided to the Organ Recipient

Benefits for physician/provider Services are provided as shown in the Benefit Summary. The Member/recipient is responsible for the 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.

4.13.5 Transplant Prior Authorization

(See also section 3.5.)

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.

4.13.6 Transplant Exclusions

In addition to the exclusions listed in section 5, the following exclusions apply to human organ/tissue transplants:

- Any transplant procedure performed at a transplant facility that has not been approved by us;
- Any transplant that is Experimental/Investigational, as determined by Providence Health Plan;
- Services or supplies for any transplant that are not specified as Covered Services in section 4.13, such as transplantation of animal organs or artificial organs;
- Services related to organ/tissue donation by a Member if the recipient is not a Member or the Member/recipient is not eligible for transplant benefits under this Plan; and

- Transplant-related travel expenses for the donor and the donor's and recipient's family members.

4.14 PRESCRIPTION DRUG BENEFIT

The Prescription Drug Benefit provides coverage for prescription drugs which are Medically Necessary for the treatment of a covered illness or injury and which are dispensed by a Participating Pharmacy pursuant to a prescription ordered by a Qualified Practitioner for use on an outpatient basis, subject to your Plan's benefits, limitations and exclusions.

Prescription Drug Definition

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.

4.14.1 Using Your Prescription Drug Benefit

Your Prescription Drug Benefit requires that you fill your prescriptions at a Participating Pharmacy.

You have access to Providence Health Plan's nationwide broad pharmacy network as published in our pharmacy directory.

Providence Health Plan Participating Pharmacies are those pharmacies that maintain all applicable certifications and licenses necessary under state and federal law of the United States and have a contractual agreement with us to provide Prescription Drug Benefits.

Participating Pharmacies are designated as retail, preferred retail, specialty and mail-order Pharmacies. To view a list of Participating Pharmacies, visit our website at www.ProvidenceHealthPlan.com. You also may contact Customer Service at the telephone number listed on your Member ID Card.

- Please present your Member ID Card to the Participating Pharmacy at the time you request Services. If you have misplaced or do not have your Member ID Card with you, please ask your pharmacist to call us.
- All covered Services are subject to the Copayments or Coinsurance listed in your Benefit Summary.
- If you choose a brand-name drug when a generic-equivalent is available, any difference in cost for Prescription Drug Covered Services will not apply to your Calendar Year Deductibles and Out-of-Pocket Maximums.
- The amount paid by a manufacturer discount and/or copay assistance programs for a brand-name drug when a generic equivalent is available may not apply towards 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 Benefit or need assistance processing your prescription.

- Copayments or Coinsurance are due at the time of purchase. If the cost of your Prescription Drug is less than your Copayment, you will only be charged the cost of the Prescription Drug.
- You may be assessed multiple Copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- You may purchase up to a 90-day supply of each maintenance 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 www.ProvidenceHealthPlan.com. (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 your Medical Supplies benefits, limitations and Copayments and/or Coinsurances. See section 4.9.1 and your Benefit Summary. Diabetes supplies do not include insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.9.4.
- Self-administered chemotherapy drugs are covered under section 4.12.8 unless the benefits under this Prescription Drug Benefit allow for a lower out-of-pocket cost to you.
- Injectable medications received in your Provider's office are covered under section 4.3.5.
- Infusions, including infused medications, received at Outpatient Facilities are covered under section 4.7.1.
- Some prescription drugs require Prior Authorization or an exception to the Formulary in order to be covered. These may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in the Providence Health Plan Prescription Drug Formulary available on our website at www.ProvidenceHealthPlan.com or by contacting Customer Service.

4.14.2 Use of Out-of-Network Pharmacies

On rare occasions, such as urgent or emergency situations, you may need to use an Out-of-Network Pharmacy. If this happens, you will need to pay full price for your prescription at the time of purchase.

To request reimbursement, you will need to fill out and submit to Providence Health Plan a Prescription Drug Reimbursement form. This form is available on our website or by contacting Customer Service. When you submit the completed Prescription Drug Reimbursement form, include any itemized pharmacy receipts, along with an explanation as to why you used an Out-of-Network Pharmacy. Submission of a claim does not guarantee payment.

If your claim is approved, the Plan will reimburse you the cost of your prescription up to our Participating Pharmacy contracted rates, less your Copayment or Coinsurance if applicable. 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.

4.14.3 Prescription Drug Formulary

The Formulary is a list of Food and Drug Administration (FDA)-approved prescription drugs. It is designed to offer drug treatment choices for covered medical conditions. Formulary status is given to drugs which meet evidence-based assessment of therapeutic effectiveness, safety, pharmacoeconomic value and offer an important advantage to existing Formulary alternatives.

The Formulary can help you and your Qualified Practitioner choose effective medications that are less costly and minimize your out-of-pocket expense. There are effective generic drug choices to treat most medical conditions.

Not all FDA-approved drugs are covered by Providence Health Plan. Non-formulary drug requests require a formulary exception, must be FDA-approved, Medically Necessary, and require by law a prescription to dispense. See Section 6.1 under Claims Involving Prior Authorization and Formulary Exception.

Newly approved FDA drugs will be reviewed by the Oregon Region Pharmacy and Therapeutics Committee for safety and Medical Necessity within 12 months after the drug becomes available on the market. In the case of an urgent situation, Providence Health Plan will authorize the use of a newly approved FDA drug during our review period so a Member does not go without Medically Necessary treatment.

To access the Formulary for your Plan, visit https://healthplans.providence.org/members/pharmacy-resources/.

4.14.4 Generic and Brand-Name Prescription Drugs

Both generic and brand-name drugs are covered benefits subject to the terms of your Benefit Summary. In general, generic drugs are subject to lower Copayments or Coinsurances than brand-name drugs. Please refer to your Benefit Summary for your Copayment or Coinsurance information.

If you request a brand-name drug, regardless of the reason or Medical Necessity, you will be responsible for the difference in cost between the brand-name and generic drug, in addition to the brand-name drug Copayment or Coinsurance indicated on the Benefit Summary. Your total cost, however, will never exceed the actual cost of the drug. The difference in cost between the brand-name and generic drug will not be applied toward your Out-of-Pocket Maximum, and you will continue to be responsible for the difference in cost after your Out-of-Pocket Maximum is met.

4.14.5 Prescription Drug Quantity

Prescription dispensing limits, including refills, are as follows:

1. Topicals, up to 60 grams;
2. Liquids, up to eight ounces;
3. Tablets or capsules, up to 100 dosage units;
4. Multi-use or unit-of-use, up to one container or package; as prescribed, not to exceed a 30-consecutive-day supply, whichever is less;
5. FDA-approved women's prescription contraceptives: up to 3-months initial dispensing, then up to 12-months subsequent dispensing at any 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 our Oregon Region Pharmacy and Therapeutics Committee. Prior Authorization is required for amounts exceeding any applicable medication dispensing limits.

4.14.6 Participating Mail-Order and Preferred Retail Pharmacies

Up to a 90-day supply of prescribed maintenance drugs (drugs are those you have been on for at least 30 days and that you anticipate continuing on in the future) purchased from a Participating mail-order or preferred retail Pharmacy will be covered subject to the following specific provisions:

1. Qualified drugs under this program will be determined by us. Not all prescription drugs are available through mail-order pharmacy.
2. Not all maintenance prescription drugs are available in 90-day allotments.
3. Copayment(s) will be applied to the quantity stated on your Benefit Summary. (Some quantity limitations and Copayments for unit of use packaging may apply).

When using a mail-order pharmacy, payment is required prior to processing your order. If Providence Health Plan removes a pharmacy from its network, we will notify you of this change at least 30 days in advance. Notification may be done via the online directory or letter depending on the circumstance.

4.14.7 Prescription Drug Limitations

Prescription drug limitations are as follows:

1. All drugs must be Food and Drug Administration (FDA) approved, Medically Necessary and require by law a prescription to dispense. Not all FDA-approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety and Medical Necessity within 12 months after the drug becomes available on the market for Formulary consideration.
2. Certain drugs require Prior Authorization for Medical Necessity, place of therapy, length of therapy, step therapy, number of doses or dispensing limits. Step therapy uses our pharmacy claims history to confirm if certain drugs have been tried first by a Member. If a drug has not been tried first, cannot be tried first, or if the drug history is not available, Prior Authorization is required. For some drugs, Providence Health Plan limit the amount of the drug the Plan will cover. You or your Qualified Practitioner can contact Providence Health Plan directly to request Prior Authorization. If you have questions regarding a specific drug, please call Customer Service.

3. Specialty drugs are injectable, infused, oral, topical, or inhaled therapies that often require specialized delivery, handling, monitoring and administration and are generally high cost. These drugs must be purchased through a Providence Health Plan designated specialty pharmacy. Due to the nature of these medications, specialty drugs are limited to a 30-day supply. Specialty drugs are listed in the Formulary. In rare circumstances, specialty medications may be filled for greater than a 30-day supply; in these cases, additional specialty cost share(s) may apply.
4. Self-injectable medications are only covered when they are being self-administered and labeled by the FDA for self-administration; in some cases, a Prior Authorization may be required for the drug. Documentation of self-administration may also be required. Drugs labeled for self-administration that are being administered by a provider will fall to the Member's medical benefit.
5. Medications, drugs or hormones prescribed to stimulate growth are not covered, except when there is a laboratory-confirmed diagnosis of growth hormone deficiency for children through 18 years of age and when prescribed for the treatment of documented pituitary destruction in adults.
6. 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.
7. Vacation supply medication refill overrides are limited to a 30-day supply once per Calendar Year, unless otherwise provided under your Plan. Additional exceptions may be granted on a case-by-case basis.
8. A 30 day supply medication refill override will be granted if you are out of medication and have not yet received your drugs from a participating mail order pharmacy.

4.14.8 Prescription Drug 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 4.3.5);
2. Amphetamines and amphetamine derivatives except when used in the treatment of narcolepsy or attention deficit and/or hyperactivity disorder in children and adults;
3. Drugs prescribed that do not relate to the prevention or treatment of a covered illness or injury;
4. Drugs used for the treatment of fertility/infertility;
5. Fluoride, for Members over 10 years of age;
6. Drugs that are not provided in accordance with our formulary management program or are not provided according to our medical policy;
7. Drugs used in the treatment of fungal nail conditions;
8. Drugs prescribed by naturopathic physicians (N.D.);
9. 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;
10. Prescription drugs, including prescription combination drugs, that contain OTC products or are available in an OTC therapeutically similar form;
11. 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;

12. Drugs, which may include prescription combination drugs, placed on a prescription-only status as required by state or local law;
13. Replacement of lost or stolen medication;
14. Drugs or medicines used to treat sexual dysfunction (this exclusion does not apply to Mental Health Covered Services);
15. Drugs used in the treatment of drug-induced fatigue, general fatigue and idiopathic hypersomnia;
16. Drugs dispensed or compounded by a pharmacist that do not have at least one FDA-approved medication in therapeutic amount;
17. 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);
18. Prenatal vitamins that contain docosahexaenoic acid (DHA);
19. Drugs used for weight loss or for cosmetic purposes;
20. Drugs that are not FDA-approved or are designated as "less than effective" by the FDA (also known as "DESI" drugs);
21. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC; and
22. 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.

4.14.9 Prescription Drug Disclaimer

Providence Health Plan is not liable for any claim, injury, demand, or judgment based on tort or other grounds (including, but not limited to, warranty or merchantability) arising out of or in any connection with the sale, compounding, dispensing, manufacturing, or use of any prescription drug covered under this Plan.

4.15 CHIROPRACTIC CARE BENEFIT

The Chiropractic Care Supplemental Benefit provides coverage for Services received from Chiropractic Care Providers provided that the Services are Medically Necessary and are within the scope of practice of the provider involved in your care.

All Chiropractic Care benefits are subject to any conditions and benefit limits stated in your Chiropractic Care Benefit Summary and in this section.

All chiropractors must be licensed in the state in which they practice and must practice within the scope of their license.

4.15.1 Chiropractic Care Providers

All Members must receive Covered Services from our nationwide network of Network chiropractors. To find a chiropractic care In-Network Provider in your area, visit our website at ProvidenceHealthPlan.com/findaprovider or call Customer Service.

You do not need a physician's referral to see a chiropractor.

In rare circumstances, our national network may not include a Network chiropractor in your area. If this happens, please contact Customer Service before making an appointment. If

Customer Service is unable to locate an In-Network Provider within a reasonable distance, authorization for use of an Out-of-Network Provider will be provided.

In some cases, you will need to pay the Out-of-Network Provider directly for the care you receive, and then submit your itemized billing statement to:

Providence Health Plan
Attn: Claims Dept.
P.O. Box 3125
Portland, OR 97208-3125

Reimbursement for services from Out-of-Network Providers is subject to Plan approval. The Plan will reimburse you the cost of your services at a Usual, Customary and Reasonable rate, less your applicable Copayment or Coinsurance. You will be responsible for all amounts over the UCR.

4.15.2 Chiropractic Care Services

Covered Services from chiropractors:

- Office visits.
- Chiropractic manipulation of the spine, joints and/or musculoskeletal soft tissue, a re-evaluation, and/or other Services in various combinations.
- Adjunctive physiotherapy which may include ultrasound, hot packs, cold packs, electrical muscle stimulation or other therapies and procedures which are Medically Necessary for the treatment of neuromusculoskeletal disorders.
- Related diagnostic X-rays and laboratory Services.

The following services are NOT covered from chiropractors:

- Preventive care services.
- Services, exams and/or treatments for conditions other than neuromusculoskeletal disorders.
- All chiropractic appliances or Durable Medical Equipment.
- Adjunctive physiotherapy not associated with chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissues.
- Clinical laboratory studies performed in a chiropractor's office.
- Venipuncture.
- Services received from a chiropractor that are not listed as a Covered Service.
- Hypnotherapy, behavior training, sleep therapy and weight programs.
- Education programs, self-care or self-help programs or any self-help physical exercise training or any related diagnostic testing.
- Transportation costs including local ambulance charges.
- Massage therapy.
- Thermography.
- Therapeutic modalities and procedures that are considered by us or our authorizing agent to be invasive.
- Emergency care and Urgent/Immediate care services.
- Any service or supply that is not permitted by state law with respect to the chiropractor's scope of practice.

- Services in excess of the benefit limits listed in the Chiropractic Care Supplemental Benefit Summary.
- Services received from Out-of-Network Providers, except as discussed in this section.

5. EXCLUSIONS

In addition to those Services listed as not covered in section 4, 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;
- Are not a Covered Service or relate to complications resulting from a Non-Covered Service, except for Services provided as Emergency Care as described in section 4.5;
- Are not furnished by a Qualified Practitioner or Qualified Treatment Facility;
- Are provided by or payable under any health plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law;
- Are provided while you are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies, except to the extent provided by 38 U.S.C. § 1729 as it relates to non-military Services provided at a Veterans Administration Hospital or facility;
- Are provided while you are in the custody of any law enforcement authorities or while incarcerated, except as provided in section 3.3;
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos, books and educational programs to which drivers are referred by the judicial system, and volunteer mutual support groups;
- Are provided to yield primarily educational outcomes, except as otherwise covered under the Preventive Services benefit described in section 4.1. An outcome is "primarily educational" if the outcome's fundamental, first, or principal character is to provide you with enduring knowledge, skill, or competence through a process of repetitive positive reinforcement over an extended length of time. An outcome is "enduring" if long-lasting or permanent;
- Are performed in association with a Service that is not covered under this Plan, except Emergency Services;
- Are provided for any injury or illness that is sustained by any Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the Member. This exclusion also applies to injuries and illnesses that are the subject of a claim settlement 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. This exclusion also applies to charges applied to the deductible of such contract or insurance. Any benefits or Services provided under this Plan that are subject to this exclusion are provided solely to assist you and such assistance does not waive our right to reimbursement or subrogation as specified in section 6.3. This exclusion also applies to Services and supplies after you have received proceeds from a settlement as specified in section 6.3.3;
- Are provided in an institution that specializes in treatment of developmental disabilities, except as provided in section 4.10.2;
- Are provided for treatment or testing required by a third party or court of law which is not Medically Necessary;
- Are Experimental/Investigational;
- Are determined by us not to be Medically Necessary for diagnosis and treatment of an injury or illness;
- Are received by a Member under the Oregon Death with Dignity Act;
- Have not been Prior Authorized as required by this Plan; and
- Relate to any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member, if such Member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony or misdemeanor punishable by up to a year's imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or mental health condition).

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 4.13;
- Services for Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment (DME), except as described in section 4.9;
- Charges for Services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to, air conditioners, air purifiers, vacuum cleaners, motorized transportation equipment, escalators, elevators, tanning beds, ramps, waterbeds, hypoallergenic mattresses, cervical pillows, swimming pools, whirlpools, spas, exercise equipment, gravity lumbar reduction chairs, home blood pressure kits, personal computers and related equipment or other similar items or equipment;
- Physical therapy and rehabilitative Services, except as provided in sections 4.6.3 and 4.7.2;

- "Telephone visits" by a physician or "environment intervention" or "consultation" by telephone for which a charge is made to the patient except as covered in section 4.3.2.
- "Get acquainted" visits without physical assessment or diagnostic or therapeutic intervention provided and online treatment sessions;
- Missed appointments;
- Non-emergency medical transportation;
- Allergy shots and allergy serums, except as provided in section 4.3.5;
- All Services and supplies related to the treatment of obesity or morbid obesity, except as provided in section 4.1.6;
- Services for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas, except as provided in section 4.1.6;
- Transportation or travel time, food, lodging accommodations and communication expenses except as provided in sections 3.6 and 4.13 and with our prior approval;
- Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
- Massage therapy;
- Light therapy for seasonal affective disorder, including equipment;
- Any vitamins, dietary supplements, and other non-prescription supplements, except as required by federal or Oregon state law;
- Services for genetic testing are excluded, except as provided in section 4.12.1. Genetic testing is not covered for screening, to diagnose carrier states, or for informational purposes in the absence of disease;
- Services to modify the use of tobacco and nicotine, except as provided in section 4.1.8 or when provided as Extra Values or Discounts (see our website at www.ProvidenceHealthPlan.com), where available;
- Cosmetic Services including supplies and drugs, except as approved by us and described in section 4;
- Services, including routine physical examination, immunizations and vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel;
- Non-sterile examination gloves;
- Sales taxes, handling fees and similar surcharges, as explained in the definition of UCR;
- Air ambulance transportation for non-emergency situations is not covered, except as provided in section 4.5.2;
- Treatments that do not meet the national standards for Mental Health and Substance Abuse professional practice;
- Services provided under a court order or as a condition of parole or probation or instead of incarceration which are not Medically Necessary;
- Personal growth services such as assertiveness training or consciousness raising;

- School counseling and support services, peer support services, tutor and mentor services; independent living services, household management training, and wraparound services that are provided by a school or halfway house and received as part of an educational or training program;
- Recreation services, therapeutic foster care, and wraparound services; emergency aid for household items and expenses; services to improve economic stability, and interpretation services;
- Evaluation or treatment for education, professional training, employment investigations, and fitness for duty evaluations;
- Community Care Facilities that provide 24-hour non-medical residential care;
- Speech therapy, physical therapy and occupational therapy services provided in connection with treatment of psychosocial speech delay, learning disorders, including mental retardation and motor skill disorders, and educational speech delay including delayed language development (except as provided in sections 4.6.3 and 4.7.2);
- Counseling related to family, marriage, sex and career including, but not limited to, counseling for adoption, custody, family planning or pregnancy, in the absence of a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis;
- Neurological Services and tests including, but not limited to, EEGs, PET, CT, MRA and MRI imaging Services, and beam scans (except as provided in section 4.4.1);
- Vocational, pastoral or spiritual counseling;
- 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 licensed acupuncturists, a physician performing acupuncture Services, naturopathic physicians, chiropractic physicians and licensed massage therapists, except as provided in section 4.15;
- Services of homeopaths; faith healers; or lay, unlicensed direct entry and certified professional midwives; and
- Services of any unlicensed providers.

Exclusions that apply to Reproductive Services:

- All services related to sexual disorders or dysfunctions regardless of gender or cause (this exclusion does not apply to Mental Health Covered Services);
- All of the following services:
    - All services related to surrogate parenting, except Maternity Services as described in section 4.8;
    - All services related to in vitro fertilization, including charges for egg/semen harvesting and storage;
    - All services related to artificial insemination, including charges for semen harvesting and storage;
    - Diagnostic testing and associated office visits to determine the cause of infertility;

- All of the following services when provided for the sole purpose of diagnosing and treating an infertile state or artificial reproduction:
    - Physical examination;
    - Related laboratory testing;
    - Instruction;
    - Medical and surgical procedures, such as hysterosalpingogram, laparoscopy, or pelvic ultrasound; and
    - Related supplies and prescriptions.

  For the purpose of this exclusion:
  - Infertility or infertile means the failure to become pregnant after a year of unprotected intercourse or the failure to carry a pregnancy to term as evidenced by three consecutive spontaneous abortions.
  - Artificial reproduction means the creation of new life other than by the natural means.
- Termination of pregnancy, unless there is a severe threat to the mother, or if the life of the fetus cannot be sustained;
- Reversal of voluntary sterilization;
- Male condoms and other over-the-counter birth control products for men; 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; and
- Services for routine eye care and vision care, vision exams/screenings, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in sections 4.1.1, 4.1.5, 4.5.3 and 4.9.2; and
- Orthoptics and vision training; and
- Services for routine eye care and vision care, vision exams/screenings, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in sections 4.1.1, 4.1.5, 4.5.3 and 4.9.2.

Exclusions that apply to Hearing Services:

- Replacement of lost or broken hearing aids are generally not covered, except for one time if a loss or damage claim is made within the first year of purchase;
- Repair of hearing aids outside of the warranty period are not covered. Repair needs during your warranty period should be discussed with your provider;
- Hearing aids prescribed and ordered prior to coverage, or prescribed or ordered after termination of coverage, whichever occurs first;
- Hearing aids, hearing therapies and/or devices, except as provided in section 4.12.11.

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 us and described in sections 4.12.6;
- Services for orthognathic surgery, except as approved by us and described in section 4.12.6;
- Services to treat temporomandibular joint syndrome (TMJ), except as provided in section 4.12.7; and
- Dentures and orthodontia, except as provided in sections 4.12.6.

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 4.9.2.

Exclusions that apply to Prescription Drugs, Medicines and Devices:

- In addition to the exclusions listed in section 4.14.8; 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.

6. 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.

6.1 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 is not a bill. An EOB explains how Providence Health Plan processed your claim, and will assist you in paying the appropriate Member responsibility to your provider. Copayment or Coinsurance amounts, Deductible amounts, services or amounts not covered and general information about our processing of your claim are explained on an EOB.

Time Frames for Processing Claims

If 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 if 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, you will be sent a separate request for the information and you will have 45 days to submit the additional information. Once the additional information from you 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 additional information is needed to process the request, Providence Health Plan will provide written notice to the Member and the provider within two business days of receiving the Prior Authorization request. The Member and the provider will have 15 days to submit the additional information. Within two business days of receipt of the additional information, Providence Health Plan will complete their review and provide written notice of its decision to the Member and the provider of their decision. 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 24 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.

6.1.1 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 (i.e., a Coordinated Care Organization) will be made in accordance with ORS 743B.470, which establishes payment requirements for claims submitted by the Oregon state Medicaid agency.

Payment of all claims will be made within the time limits required by OAR 836-080-0235, the Oregon insurance Division's administrative rule setting standards for prompt payment. Please send all claims to:

Providence Health Plan
Attn: Claims Dept.
P.O. Box 3125
Portland, OR 97208-3125

6.1.2 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.

6.2 COORDINATION OF BENEFITS

This Coordination of Benefits (COB) section applies when a Member has health care coverage under more than one Plan. The term "Plan" is defined below for the purposes of this COB section. The order of benefit determination rules 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.

6.2.1 Definitions Relating to Coordination of Benefits

Plan

Plan means any of the following that provides benefits or Services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: group and individual health insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law and group and individual insurance contracts and Subscriber contracts that pay or reimburse for the cost of dental care.
2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare Supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage listed under (1) or (2) above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan

This Plan means, as used in this COB section, the part of this contract providing health care benefits to which this COB section applies and which may be reduced because of the benefits of other plans. Any other part of this contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB

provision to coordinate other benefits.

The order of benefit determination rules listed in section 6.2.2 determine whether This Plan is a Primary plan or Secondary plan when a Member has health care coverage under more than one Plan.

When This Plan is primary, Providence Health Plan determines payment for benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, Providence Health Plan determines benefits after those of another Plan and may reduce the benefits payable 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.

6.2.2 Order of Benefit Determination Rules

When a Member is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan.
    1. Except as provided in Paragraph (2) below, a Plan that does not contain a COB provision that is consistent with the State of Oregon's COB regulations is always primary unless the provisions of both Plans state that the complying Plan is primary.
    2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.
B. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
C. Each Plan determines its order of benefits using the first of the following rules that apply:
    1. Non-Dependent or Dependent. The Plan that covers a Member other than as a Dependent, for example, as an employee, Subscriber or retiree is the Primary plan and the Plan that covers the Member as a Dependent is the Secondary plan. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Member as a Dependent; and primary to the Plan covering the Member as other than a Dependent (e.g., a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Member as an employee, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
    2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Member is a Dependent child covered by more than one Plan the order of benefits is determined as follows:
        a) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
            i. The Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary plan; or

ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

b) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   i. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
   ii. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
   iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
   iv. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the Dependent child are as follows:
      - The Plan covering the Custodial parent, first;
      - The Plan covering the spouse of the Custodial parent, second;
      - The Plan covering the non-custodial parent, third; and then
      - The Plan covering the Dependent spouse of the non-custodial parent, last.

c) For a Dependent child covered under more than one Plan of individuals who are not the parents of the Dependent child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the Dependent child.

d) For a Dependent child:
   i. Who has coverage under either or both parents' plans and also has coverage as a Dependent under a spouse's plan, the rule in paragraph (5) applies.
   ii. In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Subparagraph (a) to the Dependent child's parent(s) and the Dependent's spouse.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a Member as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same Member as a retired or laid-off employee is the Secondary plan. The same would hold true if a Member is a Dependent of an active employee and that same Member is a

Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a Member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the Member as an employee, subscriber or retiree or covering the Member as a Dependent of an employee, Subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the Member the longer period of time is the Primary plan and the Plan that covered the Member the shorter period of time is the Secondary plan.
6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than would have paid had This Plan been the Primary plan.

6.2.3 Effect on the Benefits of This Plan

When This Plan is secondary, benefits may be reduced so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

If a Member is enrolled in two or more Closed panel plans and if, for any reason, including the provision of services by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

6.2.4 Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply this COB section and to determine benefits payable under This Plan and other Plans. Providence Health Plan may get the facts needed from, or give them to, other organizations or persons for the purpose of applying this section and determining benefits payable under This Plan and other Plans covering a Member claiming benefits. Providence Health Plan 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 Providence Health Plan needs to apply this section and determine benefits payable.

6.2.5 Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

6.2.6 Right of Recovery

If the amount of the payments made by This Plan is more than what should have paid under this COB section, This Plan may recover the excess from one or more of the persons This Plan paid or for whom This Plan have paid; or any other person or organization that may be responsible for the benefits or services provided for the Member. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

6.2.7 Coordination with Medicare

In all cases, coordination of benefits with Medicare will conform with federal statutes and regulations. Medicare means Title XVIII of the Social Security Act, as enacted or amended. Medicare eligibility and how This Plan determines benefit limits 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 to 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.

6.3 THIRD-PARTY LIABILITY/SUBROGATION

The following provisions will apply when you or any other Member has received Services for a condition for which one or more third parties may be responsible. "Third party" means any person other than the Member (the first party to the provisions of this Plan), 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 us 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 9.4. 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 the Plan under these provisions.

6.3.1 Third-Party Liability/Subrogation and How It Affects You

Third-party liability refers to claims that are in whole or part the responsibility of someone besides the 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, the Plan 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 the Plan makes claim payments 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 the 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, the Plan is 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 has a security interest in and lien upon any recovery to the extent of the amount of benefits paid by the Plan and for the Plan's expenses in obtaining a recovery. If the Member should either decline to pursue a claim against a third party that the Plan believes is warranted or refuse to cooperate with the Plan in any third party claim that the Member does pursue, the Plan has 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, the Plan needs 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 Providence Health Plan office. A Providence Health Plan employee who specializes in third-party liability/subrogation can discuss these procedures and what you or the Member needs to do.

6.3.2 Proceeds of Settlement or Recovery

Subject to paragraph 6.3.4 below, if for any reason 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 the Plan 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 the Plan for the condition, calculated using the 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 the Plan's first priority to this repayment and assigns to us 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 the Plan. 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 the Plan directly from the settlement or recovery in the amount provided by this section.

The Member must complete the Plan's trust agreement, by which the Member and any Member's attorney (or other agent) must confirm the obligation to reimburse the Plan 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 the Plan. The agreement must remain in effect and the Plan 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 the Plan to exercise the Plan's rights under this section, it serves as a reminder to the Member and directly obligates any Member's attorney to act in accord with the Plan's rights.

6.3.3 Suspension of Benefits and Reimbursement

Subject to paragraph 6.3.4 below, after the Member has received proceeds of a settlement or recovery from the third party, the Member is responsible for payment of all medical expenses for the continuing treatment of the illness or injury that 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 the Plan as required by this section, the Plan is entitled to offset future benefits otherwise payable under this Plan, or under any future contract or plan with Clackamas County, 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 the 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 the 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 the Plan has not approved in advance. In no event shall the amount reimbursed to the Plan be less than the maximum permitted by law.

6.3.4 Special Rules for Motor Vehicle Accident Cases

If the third party recovery is payable to you or any enrolled Family Member as the result of a motor vehicle accident or by a motor vehicle liability or underinsured insurer, the rules in paragraphs 6.3.2 and 6.3.3 above are modified as provided below.

Before the Plan will be entitled to recover 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.

7. PROBLEM RESOLUTION

7.1 INFORMAL PROBLEM RESOLUTION

All employees of Providence Health Plan share responsibility for assuring Member satisfaction. If you have a problem or concern about your coverage, including benefits or Services by In-Network Providers or payment for Services by Out-of-Network Providers, please ask for Providence Health Plan's 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, Providence Health Plan will make efforts to accommodate your requirements. Please contact Customer Service for help with whatever special needs you may have.

7.2 MEMBER GRIEVANCE AND APPEAL

Definitions:

Adverse Benefit Determination

An Adverse Benefit Determination means a:

- Denial of eligibility for or termination of enrollment in this Plan;
- Rescission or cancellation of coverage under this Plan;
- Source-of injury exclusion, network exclusion, Annual benefit limit or other limitation on otherwise Covered Services;
- Determination that a health care item or service is Experimental/Investigational or not Medically Necessary; or
- Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care.

Appeal

A type of Grievance that is a written request from a Member or an Authorized Representative of the Member requesting further consideration of an Adverse Benefit Determination.

Authorized Representative

An individual who by law or by the authorization of a Member may act on behalf of the Member.

Concurrent Care

An approved ongoing course of treatment to be provided over a period of time or for a specified number of treatments.

Grievance

A communication from a Member or an Authorized Representative of a Member expressing dissatisfaction with an Adverse Benefit Determination, without specifically declining any right to Appeal or review, that is:

- In writing, for an internal Appeal or an external review; or in writing or orally, for an expedited response or an expedited external review; or
- A written complaint submitted by a Member or an Authorized Representative of a Member regarding the:
    - Availability, delivery or quality of a health care service;

- Claims payment, handling or reimbursement for health care services and, unless the Member has not submitted a request for an internal Appeal, the complaint is not disputing an Adverse Benefit Determination; or
- Matters pertaining to the contractual relationship between a Member and Providence Health Plan.

7.2.1 Your Grievance and Appeal Rights

If you disagree with Providence Health Plan's decision about your medical bills or health care services, you have the right to an 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 Providence Health Plan will consider that information in the 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. Providence Health Plan 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 Providence Health Plan's decision on your Grievance or Appeal of a denied Prior Authorization or Concurrent Care request, you may request an expedited review by calling Customer Service at 503-574-7500 or 800-878-4445 outside of 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, you will be notified of the 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 reconsideration of the decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. Providence Health Plan will then notify you of the reconsideration decision within 24 hours of receiving your request.

7.2.2 Internal Grievance or Appeal

You must file your internal Grievance or Appeal within 180 days of the date on the notice of the initial Adverse Benefit Determination, or that initial determination will become final. Please advise Providence Health Plan of any additional information that you want considered in 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 for the review process. Your Grievance or Appeal will be reviewed by Providence Health Plan staff not involved in the initial determination. You may present your case in writing. Once a final determination is made you will be sent a written explanation of the decision.

7.2.3 External Review

If you are not satisfied with the internal Grievance or Appeal decision and your Appeal is of an Adverse Benefit Determination that involves (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care or (e) an exception to the Plan's prescription drug formulary, you may request an external review by an IRO. Your request must be made in writing within 180 days of receipt of the internal Grievance or Appeal decision, or that internal decision will become final. If you agree, Providence Health Plan may waive the requirement that you exhaust the internal review process before beginning the External Review process. Providence Health Plan will notify the Oregon Insurance Division within two business days of receiving your request for external review, at which point an IRO will be assigned to the case by the Oregon Insurance Division and Providence Health Plan will forward complete documentation regarding the case to the IRO.

If you request an external review you must agree to authorize release of medical records needed by the IRO and submit any additional information to the IRO no later than five days after the appointment of the IRO, or 24 hours in cases of expedited review. The IRO is entirely independent of the Plan and Providence Health Plan and performs its review under a contract with the Oregon Insurance Division. The IRO will notify you and Providence Health Plan of its decision within three days for expedited reviews and within 30 days when not expedited. **The Plan and Providence Health Plan agree to be bound by and to comply with the IRO decision when the decision involves, (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care or (e) an exception to the Plan's prescription drug formulary.**

The Plan pays all costs for the handling of external review cases and Providence Health Plan administers these provisions in accordance with the insurance laws and regulations of the State of Oregon. **If we do not comply with the IRO decision, you have the right to sue us under applicable Oregon law.**

7.2.4 How to Submit Grievances or Appeals and Request Appeal Documents

To submit your Grievance or Appeal or requests for External Review, you may contact Customer Service at 503-574-7500 or 800-878-4445. If you are hearing impaired and use a Teletype (TTY) Device, please call the TTY line at 711. Written Grievances or Appeals should be sent to:

Providence Health Plan
Appeals and Grievance Department
P.O. Box 4158
Portland, OR 97208-4158

You may fax your Grievance or Appeal 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

If your plan is governed by ERISA, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). If your plan is not governed by ERISA, you may contact the Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789.

8. 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 and your Employer must provide Providence Health Plan with evidence of eligibility as requested.

8.1 EMPLOYEE ELIGIBILITY AND ENROLLMENT

8.1.1 Employee Eligibility Date

An employee is eligible for coverage as specified in the Eligible Employee definition.

8.1.2 Employee Effective Date

Coverage begins for an Eligible Employee as specified in the Effective Date of Coverage definition.

8.1.3 Employee Enrollment

The Eligible Employee must enroll on forms (paper or electronic) provided and/or accepted by Clackamas County. To obtain coverage, an Eligible Employee must enroll within 30 days to enroll after becoming eligible. An enrolled Eligible Employee is referred to as the Subscriber.

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.

In certain situations, you and/or your Eligible Family Dependents may qualify to enroll during a special enrollment period. See section 8.3 for additional information.

8.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

8.2.1 Eligibility Date

Coverage begins for each Eligible Family Dependent on:

1. The Effective Date of Coverage for the Subscriber if the individual is an Eligible Family Dependent on that date;
2. For any Eligible Family Dependents acquired on the date of the Subscriber's marriage, on the first day of the calendar month following receipt of the enrollment request, within 60 days of the subscriber's marriage;
3. The date of birth of the biological child of the Subscriber or Spouse;
4. The date a child is placed with the Subscriber or Spouse for the purpose of adoption by the Subscriber or Spouse;
5. The date the Subscriber or Spouse is required to provide health coverage to a child under a qualified medical child support court or administrative order; or
6. The date on which legal guardianship status begins.

8.2.2 Additional Requirements for Eligible Family Dependent Coverage

An Eligible Employee may cover Eligible Family Dependents ONLY if the Eligible Employee is also covered, and Clackamas County receives the completed enrollment form requesting Dependent coverage.

8.2.3 Eligible Family Dependent Enrollment

You must enroll Eligible Family Dependents on forms provided and/or accepted by Clackamas County. No Eligible Family Dependent will become a Member until Clackamas County approves that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within 30 after becoming eligible as indicated in section 8.2.1 (see section 8.2.4 regarding newborn and adopted children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 8.3.

8.2.4 Newborn Eligibility and Enrollment

A newborn or adopted child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption as long as enrollment occurs within 60 days from birth or placement and additional Premium, if any, is paid to Clackamas County. 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 8.2.3 and 8.3.

8.2.5 Open Enrollment Period

Clackamas County will provide an Open Enrollment Period each Plan Year. The Effective Date of Coverage for new Members who enroll during the Open Enrollment Period is the first day of the Plan Year for which they enroll.

8.2.6 Changes in Eligibility

When an eligibility change occurs, you need to make sure Clackamas County is notified of the change. Address changes can be made by contacting Clackamas County Benefits & Wellness.

For the following changes, you, as the Subscriber, must obtain an enrollment form from Clackamas County's benefit office. You need to submit this form to your Employer for you and all your Eligible Family Dependents when:

- You marry and wish to enroll your new Spouse;
- A Dependent's limiting age occurs; or
- You or one of your Dependents has a legal name change.

If you have questions regarding eligibility changes, please contact Clackamas County Benefits & Wellness.

8.2.7 Members No Longer Eligible for Coverage

If you divorce or are legally separated, your Spouse is no longer eligible for coverage as a Dependent. You must disenroll your Spouse as a Dependent from your Plan at the time the divorce or legal separation is final. Your Spouse's children will be able to continue coverage under the Plan so long as the children continue to qualify as your Eligible Family Dependents.

You must inform Clackamas County of these changes by completing a new enrollment form. Check with Clackamas County's benefits office or contact Customer Service 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 section 10. Ask Clackamas County or call Customer Service for continuation coverage eligibility information.

8.3 SPECIAL ENROLLMENT PERIODS

If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your Spouse) during a previous enrollment period (as stated in sections 8.1 and 8.2), you may be eligible to enroll yourself or the Eligible Family Dependent during a "special enrollment period" provided that you request enrollment within 60 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
- Enroll in any benefit option offered by the Employer for which the Subscriber and Eligible Family Dependent is eligible.

8.3.1 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, the Plan 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 the Plan 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 benefits; and the individual applies for coverage under this Plan within 60 days after the claim is denied.

Effective Date: Coverage under this Plan will take effect on the first day after the other coverage ended.

8.3.2 New 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, birth, adoption or placement for adoption; the Plan 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 60 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.

Effective Date:

- in the case of marriage, on the first day of the calendar month following Clackamas County's receipt of the enrollment request, or on an earlier date as agreed to by Clackamas County; 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.

8.3.3 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 or minor child under your Health Benefit Plan, the Plan 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 60 days after the issuance of the court order.

Effective Date: The date specified in the court order.

8.3.4 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 arrangement, the Plan 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.

8.4 LEAVE OF ABSENCE AND LAYOFFS

A Subscriber on leave of absence or layoff status may continue to be covered under this Plan as though actively at work for a period of time, if any, as stated in the Eligible Employee definition. An Employee who returns to work as an Eligible Employee after coverage has lapsed must re-enroll for coverage as specified in section 8.1.3.

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), is administered in accordance with those Acts and this Summary Plan Description.

9. TERMINATION OF MEMBER COVERAGE

9.1 TERMINATION DATES

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 Clackamas County;
3. The last day of the coverage period in which a Subscriber no longer qualifies as a Subscriber, as stated in the Summary Plan Description;
4. The date a Member enters full-time military, naval or air service, except as provided under federal USERRA requirements;
5. The last day of the coverage period in which a Subscriber retires;
6. 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;
7. For a Family Member, the date the Subscriber's coverage terminates;
8. For a Family Member, the last day of the month in which the individual no longer qualifies as an Eligible Family Dependent;
9. For any benefit, the date the benefit is deleted from this Plan;
10. For a Member, the date of disenrollment from this Plan as described in section 9.4;
11. For a Member, the date any fraudulent information is provided; or
12. For a Member, the date we discover any breach of contractual duties, conditions or warranties, as determined by us.
13. For a Subscriber that is a Non-Medicare Eligible Early Retiree, the last day of the month in which the Retiree becomes eligible for Medicare.

You and the Employer are responsible for advising Clackamas County 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 Clackamas County.

See section 7, Problem Resolution, for your Grievance and Appeal rights.

9.2 TERMINATION AND RESCISSION OF COVERAGE DUE TO FRAUD OR ABUSE

Coverage under this Plan, either for you or for your covered Dependent(s), may be rescinded (meaning your coverage is retroactively canceled) or terminated in case of a fraud or intentional misrepresentation of material fact by you or by your covered Dependent in obtaining, or attempting to obtain, benefits under this Plan.

If coverage is rescinded, the Plan will retain any money you paid for coverage as liquidated damages and will have the right to recover from you or from your covered Dependents the benefits paid as a result of such wrongful activity. Providence Health Plan will provide all affected Plan participants with 30 days' notice before rescinding coverage.

9.3 NON-LIABILITY AFTER TERMINATION

Upon termination of this Plan, Clackamas County shall have no further liability beyond the effective date of the termination unless the Member continues, without lapse of membership, under another Clackamas County plan.

9.4 DISENROLLMENT FROM THIS PLAN

"Disenrollment" means that your coverage under this Plan is terminated 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 Clackamas County or Providence Health Plan employees; or
4. You have allowed a non-Member to use your Member ID Card to obtain Services.

9.5 NOTICE OF CREDITABLE COVERAGE

Providence Health Plan will provide upon request written certification of the Member's period of Creditable Coverage when:

- A Member ceases to be covered under this Plan;
- A Member on COBRA coverage ceases that coverage; and
- A Member requests a Notice of Creditable Coverage within 24 months of the termination of coverage.

9.6 CLACKAMAS COUNTY'S RIGHT TO TERMINATE OR AMEND PLAN

Clackamas County 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 Clackamas County.

10. 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 and which are generally outlined below. Please contact Clackamas County as soon as possible for details if you think you may qualify for group COBRA or state continuation coverage.

10.1 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.

10.1.1 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.

10.1.2 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.

10.1.3 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 who is properly enrolled under the terms of this Plan during the COBRA continuation period will be a qualified beneficiary.

10.1.4 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 Clackamas County 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 Clackamas County 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.

10.1.5 Type of COBRA Continuation Coverage

A qualified beneficiary will be provided the same coverage that was in effect immediately prior to the qualifying event.

10.1.6 COBRA Election Rights

A Subscriber or their Spouse or Domestic Partner may elect continuation coverage for all covered Family Members. In addition, each Family Member has an independent right to elect COBRA. Thus, a Family Member may elect continuation coverage even if the Subscriber does not.

10.1.7 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 Clackamas County 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.

10.1.8 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 their 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 Clackamas County 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 Dependent child 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.

10.1.9 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.

10.1.10 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/.

10.1.11 When COBRA Continuation Coverage Ends

COBRA Continuation coverage will end automatically for you and your Family Members when any of the following events occurs:

- Clackamas County 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;
- 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.

11. MEMBER RIGHTS AND RESPONSIBILITIES

11.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES

As a Member of Providence Health Plan, you should know what to expect from Providence Health Plan, as well as what Providence Health Plan asks from you. Nobody knows more about your health than you and your doctor. Providence Health Plan takes 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. Providence Health Plan wants you to have a positive experience, and 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, the providers, and the benefits and Services you have available to you as a Member.
- Receive information that helps you select a Qualified Practitioner whom you trust and with whom you feel comfortable.
- A candid discussion of appropriate or Medically Necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Receive information and clinical guidelines from your health care provider or your health plan that will enable you to make thoughtful decisions about your health care.
- Actively participate in decisions that relate to your health and your medical care through discussions with your health care provider or through written advance directives.
- Have access to medical Services that are appropriate for your needs.
- Express a concern or an Appeal and receive a timely response from Providence Health Plan.
- Have your claims paid accurately and promptly.
- Request a review of any service not approved, and to receive prompt information regarding the outcome.
- Be informed about and make recommendations regarding Providence Health Plan's member rights and responsibilities policy.
- Refuse care from specific providers.

Members have the responsibility to:

- Read and understand the information in and the terms of your Plan. Neither the Plan nor Providence Health Plan will have liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact Customer Service. Providence Health Plan will assist you in understanding and complying with the terms of the Plan.
- Talk openly with your physician or provider, understand your health problem and work toward a relationship built on mutual trust and cooperation.
- Develop mutually agreed upon treatment goals with your Qualified Practitioner, to the degree possible, and follow treatment plans and instructions.
- Supply to the extent possible information Providence Health Plan 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 Customer Service know if you have concerns or if you feel that any of your rights are being compromised, so that Providence Health Plan 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.

<u>Providence Health Plan has the responsibility to:</u>

- Respect and honor your rights.
- Ensure timely access to appropriate health care Services.
- Enable you to see physicians or providers who meet your needs.
- Develop a variety of benefits to serve you well.
- Assure the ongoing quality of our providers and Services.
- Contract with providers who are capable, competent, and committed to excellence.
- Make it easy and convenient for you to Appeal any policy or decision that you believe prevents you from receiving appropriate care.
- Provide you with accurate up-to-date information about Providence Health Plan and In-Network Providers.
- Provide you with information and services designed to help you maintain good health and receive the greatest benefit from the services we offer.
- Ensure privacy and confidentiality of your medical records with access according to law.
- Ensure that your interests are well represented in decisions about Providence Health Plan policy and governance.
- Encourage physicians and providers to make medical decisions that are always in your best interest.

11.2 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 Clackamas County's Group Plan, you are entitled to certain rights and protections under Oregon law, which provides that all Plan participants are entitled to:

1. **Receive from Providence Health Plan information maintained about you by your Employer's group plan**
    - You are entitled within 30 days to access to recorded personal information, 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 10.1.
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 7, the Plan offers 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 7.2 of this Summary Plan Description. If the Member elects to seek external review under section 7.2.4, both the Plan and the Member will be bound by the Independent Review Organization (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 7.2.

    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 or an arbitrator, neither party shall under any circumstance be liable to the other for any special, incidental, or consequential damages, or for any tort liability (including any punitive or exemplary damages), in any way related to this Plan.

12. 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.

12.1 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 Clackamas County has determined satisfies the QMSCO standards set forth below.

"Procedures" means the Qualified Medical Child Support Order procedures as prescribed in this section.

"Designated Representative" means a representative designated by an Alternate Recipient to receive copies of notices that are sent to the Alternate Recipient with respect to an Order.

12.2 NOTICE UPON RECEIPT OF ORDER

Upon the receipt of any Order, Clackamas County 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.

12.3 NOTICE OF DETERMINATION

Within a reasonable period after its receipt of the Order, Clackamas County 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, the Order will not be considered to be a QMCSO.

12.4 ENROLLMENT OF ALTERNATE RECIPIENT

An Alternate Recipient with respect to an Order determined to be a QMCSO who properly submits the applicable enrollment forms to Clackamas County will become covered under the Plan to which such Order applies as soon as practicable after the applicable enrollment forms are received. An Alternate Recipient will be eligible to become covered under the Plan as of a particular date without regard to any open enrollment period restrictions otherwise applicable under the Plan.

12.5 COST OF COVERAGE

An Alternate Recipient will be treated as having been 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.

12.6 REIMBURSEMENT OF PLAN EXPENSES

Unless the terms of the Order provide otherwise, any payments to be from the Plan as reimbursement for group health expenses paid either by the Alternate Recipient, or by the custodial parent or legal guardian of the Alternate Recipient, will not be paid to the 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.

12.7 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.

12.8 TREATMENT OF NATIONAL MEDICAL SUPPORT NOTICE

If Clackamas County 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 Clackamas County to satisfy the QMCSO standards prescribed above, then the National Notice shall be deemed to be a QMSCO respect to such child.

Clackamas County, upon determining that the National Notice is a QMSCO, 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.

Clackamas County 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.

13. GENERAL PROVISIONS

13.1 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.

13.2 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.

13.3 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.

13.4 FAILURE TO PROVIDE INFORMATION OR PROVIDING INCORRECT OR INCOMPLETE INFORMATION

Members warrant that all information contained in applications, questionnaires, forms, or statements submitted to Clackamas County and to Providence Health Plan to be true, correct, and complete. If a Member willfully fails to provide information required to be provided under this Plan or knowingly provides incorrect or incomplete information, then the Member's rights may be terminated. See section 9.4.

13.5 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.

13.6 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.

13.7 LEGAL ACTION

No civil action may be brought under state or federal law to recover benefits from the Plan until receipt of a final decision under the Member Grievance and Appeal process specified in section 7.2 of the Summary Plan Description, unless the Member's benefits under the Plan are subject to the Employee Retirement Income Security Act (ERISA), in which case the Member is permitted either to bring a civil action under ERISA in federal court after receiving a decision from the First Level of Appeal or to bring such an action after receipt of a final grievance decision. An appeal from a final Grievance decision may lie with an Independent Review Organization (IRO). In the event a right to IRO review exists and the Member elects to seek such review, the IRO decision will be binding and final, as indicated in section 7.2.4. No civil action under ERISA or otherwise 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 7.2. If ERISA does not apply (see section 11.2), the action must be brought in Oregon state court, either in the Member's county of residence or such other county as mutually agreed upon between Member and the Plan. In general, ERISA applies if this is an employer-sponsored plan, other than a government plan or church plan.

13.8 LIMITATIONS AND 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 Clackamas County shall be paid solely in accordance with the terms and provisions of such plan, and nothing in this Plan shall operate or be construed in any way to modify, amend, or affect the terms and provisions of such other plan.

13.9 MEMBER RESPONSIBILITY

It is your responsibility to read and to understand the terms of this Plan. Neither Clackamas County nor Providence Health Plan will have any liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact Providence Health Plan. They will assist you in understanding and complying with the terms of the Plan.

13.10 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.

13.11 NON-TRANSFERABILITY OF BENEFITS

No person other than a Member is entitled to receive benefits under this Plan. Such right to benefits is nontransferable.

13.12 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 Clackamas County. No shareholder, director, officer, or employee of Clackamas County 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.

13.13 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 Clackamas County nor Providence Health Plan is liable for any claim or demand due to damages arising out of, or in any manner connected with, any injuries suffered by you while receiving such Services.

13.14 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.

13.15 NOTICE

Any notice required of Clackamas County or Providence Health Plan under this Plan shall be deemed to be sufficient if mailed to the Subscriber at the address appearing in 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, P.O. Box 3125, Portland, OR 97208.

13.16 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 6.1.1 regarding timely submission of claims.

13.17 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. PHP'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 Clackamas County and Providence Health Plan.

13.18 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.

13.19 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 our 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.

13.20 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.

13.21 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 Clackamas County to deduct the overpayment from future benefit payments under this Plan.

13.22 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.

13.23 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.

13.24 SUGGESTIONS

You are encouraged to make suggestions to us. Suggestions may be oral or written and should be directed to the Customer Service Team at our administrative office.

13.25 VETERANS' RIGHTS

The Plan will provide benefits to employees 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) An employee who takes unpaid military leave, or who separates from the employment of Clackamas County 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 section10. 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 employee's absence for the purpose of performing military service begins; or
    2. The date the employee fails to timely return to employment or reapply for a position with Clackamas County upon the completion of such military service.

13.26 WORKERS' COMPENSATION INSURANCE

This Plan is not in lieu of, and does not affect, any requirement for coverage under any workers' compensation act or similar law.

14. PLAN ADMINISTRATION

14.1 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.

14.2 PLAN INFORMATION

Plan Name: Clackamas County Peace Officers Association Open Option Grandfathered Plan
Plan No. 100112
Employer ID No. 936002286

14.3 PLAN DATES

The Plan Year begins on January 1st and ends on December 31st.

14.4 PLAN SPONSOR INFORMATION

Clackamas County
Benefits & Wellness Division
Public Services Building
2051 Kaen Road, Suite 310
Oregon City, OR 97045
503-655-8459

14.5 ADMINISTRATIVE SERVICES PROVIDED BY

Providence Health Plan
P.O. Box 4447
Portland, OR 97208-4447
800-878-4445

14.6 AGENT FOR SERVICE OF LEGAL PROCESS

Clackamas County
Office of County Counsel
2051 Kaen Rd.
Oregon City, OR 97045

14.7 ADMINISTRATIVE SERVICES

The Employer 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 are specified in the Administrative Services Agreement that has been executed by the Employer and Providence Health Plan.

14.7.1 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.

14.8 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.

14.9 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.

14.10 AMENDMENT OR TERMINATION OF PLAN

14.10.1 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.

14.10.2 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 Chair of the Board of County Commissioners or their designee shall be conclusive evidence of the adoption and effectiveness of the instrument.

14.10.3 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.

14.11 PROTECTED HEALTH INFORMATION

14.11.1 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 PHI obtained from Providence Health Plan 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. Benefit Managers;
    3. Benefit Analysts;
    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.

14.11.2 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 14.11.1(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.

15. DEFINITIONS

The following are definitions of important capitalized terms used in this Summary Plan Description.

Adverse Benefit Determination
See section 7.

Ambulatory Surgery Center
Ambulatory Surgery Center means an independent medical facility that specializes in elective same-day or outpatient surgical procedures.

Annual
Annual means once per Calendar Year.

Appeal
See section 7.

Approved Clinical Trial
Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment or cancer or other life-threatening disease or condition and is one of the following:

- A federally funded or approved trial;
- A clinical trial conducted under an FDA investigational new drug application; or
- A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Authorized Representative
See section 7.

Benefit Summary
Benefit Summary means the documents with that title that are part of your Plan and summarize the benefit provisions under your Plan.

Calendar Year
Calendar Year means a 12-month time period beginning January 1st and ending December 31st.

Chemical Dependency
Chemical Dependency 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. Chemical Dependency does not mean an addiction to, or dependency on tobacco, tobacco products, or foods.

Clackamas County
Clackamas County means the entity that is the Sponsor of this Plan.

Clackamas County Peace Officers Association Open Option Grandfathered Plan

Clackamas County Peace Officers Open Option Grandfathered Plan means this Summary Plan Description and includes the provisions of the Benefit Summaries and any Endorsements, amendments and addendums that accompany this document.

Cochlear Implant

See section 4.12.11.

Coinsurance

Coinsurance means the dollar amount that you are responsible to pay to a health care provider, after your claim has been processed by Providence Health Plan. Your Coinsurance for a Covered Service is shown in the Benefit Summary and is a percentage of the charges for the Covered Service. Your Coinsurance will usually be less when you receive Covered Services from an In-Network Provider.

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 section 4;
2. Medically Necessary;
3. Not listed as an Exclusion in the Benefit Summary or in sections 4 and 5; 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 3.11.1.

Dependent

Dependent means a person who is supported by the Subscriber, or supported by the Subscriber's Spouse or Domestic Partner. See also Eligible Family Dependent.

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 with a member of the same sex; and
    - Has legally registered a Declaration of Domestic Partnership and obtained a Certificate of Registered Domestic Partnership in accordance with Oregon state law.
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 4.3.3).

Effective Date of Coverage

Effective Date of Coverage means the date upon which coverage under this Plan commences for a Member.

Eligibility Waiting Period

Eligibility Waiting Period means the period of employment, as specified in the Eligible Employee definition, that an otherwise Eligible Employee must complete before coverage will begin under this Plan. The Eligibility Waiting Period will not exceed 90 days. When the Eligibility Waiting Period is 90 days, coverage is effective on the 91st day. If an employee enrolls on a special enrollment date, any period before such special enrollment is not an Eligibility Waiting Period.

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 8.1.

1. Employment Status: Permanent. (On-call, temporary, substitute, and seasonal employees are not eligible.)
2. Employment Category/Class: Open Option Peace Officers Association Employees, COBRA-participants and non-Medicare eligible Early Retirees.
3. Work Hours: Peace Officers regularly scheduled for at least 20 hours per week. Not applicable to COBRA and Early Retiree.
4. Eligibility Waiting Period: Active -Two months.* A new Eligibility Waiting Period does not apply if an employee returns to work in eligible status from a period of layoff or leave of absence, provided that such period did not exceed 180 days. The Eligibility Waiting Period is also waived if an employee has continuously participated in COBRA continuation coverage during the layoff period and is rehired within 18 months from the date of layoff. (*Note: Effective July 1, 2021, the Eligibility Waiting Period for new employees hired on or after this date will be the first of the month following date of hire.)
5. Effective Date of Coverage: Active: First of the month following completion of the Eligibility Waiting Period. COBRA: First day following loss of Active coverage. Early Retiree: First of the month following retirement.
6. Location: Employees who work or reside in Oregon.
7. Leave of Absence Status: An otherwise Eligible Employee on an Employer-approved Leave of Absence shall remain eligible during the first six months of leave of

absence. Absences extending beyond this period are subject to the COBRA provisions of this Summary Plan Description.

8. Layoff/Rehire: If the Eligible Employee is rehired within six months, the Eligibility Waiting Period is waived.
9. Retirement Status: Non-Medicare eligible retired employees are eligible.

Eligible Family Dependent

Eligible Family Dependent means:

1. The legally recognized Spouse or Domestic Partner of a Subscriber;
2. In relation to a Subscriber, the following individuals:
    a) A biological child, step-child, or legally adopted child;
    b) An unmarried grandchild for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support;
    c) A child placed for adoption with the Subscriber or Spouse;
    d) An unmarried individual for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support; and
    e) A child for whom the Subscriber or Spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law.

Placement for adoption means the assumption and retention by a Subscriber or Spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption). Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.

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:

a) Developmentally or physically disabled;
b) Incapable of self-sustaining employment prior to the limiting age; and
c) Unmarried.

Proof of incapacity must be provided to us 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. Thereafter, Providence Health Plan 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 Providence Health Plan, the individual's coverage will not continue beyond the last date of eligibility.

See section 8.2.4 for information on when and how to add a newborn to the Plan.

Emergency Medical Condition

See section 4.5.1.

Emergency Medical Screening Exams

See section 4.5.1.

Emergency Services
See section 4.5.1.

Employer
Employer means Clackamas County, an Oregon employer, and the Plan Sponsor.

Endorsement
Endorsement means a document that amends and is part of this Plan.

Essential Health Benefits
Essential Health Benefits means the general categories of services established under section 1302(b) of the Patient Protection and Affordable Care Act (PPACA) and applicable regulations:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental Health and substance use disorder (Substance Abuse) services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including dental and vision care.

Exclusion
Exclusion means an item or service that is not a Covered Service under the Plan.

Experimental/Investigational
Experimental/Investigational means Services for which current, prevailing, evidence-based, peer-reviewed medical literature does not demonstrate the safety and effectiveness of the Service for treating or diagnosing the condition or illness for which its use is proposed. In determining whether Services are Experimental/Investigational the Plan considers a variety of criteria, which include, but are not limited to, whether the Services are :

- Approved by the appropriate governmental regulatory body;
- Subject to review and approval of an institutional review board (IRB) or are currently offered through an approved clinical trial;
- Offered through an accredited and proficient provider in the United States;
- Reviewed and supported by national professional medical societies;
- Address the condition, injury, or complaint of the Member and show a demonstrable benefit for a particular illness or disease;
- Proven to be safe and efficacious; and
- Pose a significant risk to the health and safety of the Member.

The experimental/investigational status of a Service may be determined on a case-by-case basis. Providence Health Plan will retain documentation of the criteria used to define a Service as Experimental/Investigational and will make this available for review upon

request.

Family Member
Family Member means a Dependent who is properly enrolled in and entitled to Covered Services under this Plan.

Fiduciary
Fiduciary means a person entrusted to act on behalf of the Plan, consistent with the duties and obligations of plan administration as set forth under applicable law.

Global Fee
See section 4.13.2.

Grievance
See section 7.

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 Employee Retirement Income Security Act (ERISA).

Hearing Aid
See section 4.12.11.

Hearing Assistance Technology
See section 4.12.11.

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 Abuse or Mental Health disorders.

In-Network Provider

In-Network Provider means an Outpatient Surgical Facility, Home Health Provider, Hospital, Qualified Practitioner, Qualified Treatment Facility, Skilled Nursing Facility, or Pharmacy that has a written agreement with Providence Health Plan to participate as a health care provider for this Plan. For Native American Indian and Alaskan Native Members, Covered Services obtained through Indian Health Services are considered to be Covered Services obtained from an In-Network Provider.

In-Plan

In-Plan means the level of benefits specified in the Benefit Summary and this Summary Plan Description for Covered Services that are provided by an In-Network Provider.

Late Enrollee

Late Enrollee means a person eligible to enroll under a Special Enrollment Period, as described in section 8.3.

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 abuse 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 disorder covered by diagnostic categories listed in the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV) or the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

Non-Medicare Eligible Early Retiree
Non-Medicare Eligible Early Retiree means a Subscriber who retires from employment with Clackamas County and is eligible to enroll in this Plan.

Open Enrollment Period
Open Enrollment Period means a period during each Plan Year, as established by Clackamas County, 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 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 for this Plan.

Out-of-Plan
Out-of-Plan means the level of benefits specified in the Benefit Summary and this Summary Plan Description for Covered Services provided by Out-of-Network Providers.

Out-of-Pocket Maximum
See section 3.11.2.

Outpatient Surgical Facility
Outpatient surgical facility means any licensed public or private establishment that has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgery. It does NOT provide Services or accommodations for patients to stay overnight.

Participating Pharmacy
Participating Pharmacy means pharmacy that has a signed contract with Providence health Plan to provide medications and other Services at special rates. There are four types of Participating Pharmacies:

1. Retail: A Participating Pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions.

2. Preferred Retail: A Participating Pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.
3. Specialty: A Participating Pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.
4. Mail Order: A Participating Pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.

Plan

Plan means the Clackamas County group health plan, as set forth in this document, the Summary Plan Description, and includes the provisions of any Benefit Summary 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.

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 Qualified Practitioner specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider.

(Note: Not all Qualified Practitioners are Primary Care Providers. To obtain a listing of In-Network Primary Care Providers, please see the Provider Directory online or call Customer Service.)

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 Providence Health Plan's 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, additional information may be required about the Member's condition and/or the Services requested. Providence Health Plan 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 Plan. Services that require Prior Authorization are shown in section 3.5.

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 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, 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 corrects a congenital deformity or anomaly that results in a functional impairment.

Retail Health Clinic
Retail Health Clinic means a walk-in clinic located in a retail setting such as a store, supermarket, or pharmacy that treats uncomplicated minor illnesses and injuries.

Service
Service means a health care related procedure, surgery, consultation, advice, diagnosis, referral, treatment, supply, medication, prescription drug, device or technology that is provided to a Member by a Qualified Practitioner.

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 or non-Medicare Eligible Early Retiree of Clackamas County who is eligible for benefits and is properly enrolled in accordance with the provisions of this

Summary Plan Description.

Summary Plan Description (SPD)

Summary Plan Description (SPD) means the description of the Plan as contained in this document, and includes the provisions of any Benefit Summary, any Endorsements, amendments and addendums that accompany this document, and those policies maintained by Providence Health Plan which clarify any of these documents.

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

Urgent Care means Services that are provided for unforeseen, non-life threatening, minor illnesses and injuries which require immediate attention, such as ear, nose and throat infections and minor sprains and lacerations.

Urgent Care Covered Services are provided when your medical condition meets the guidelines for Urgent Care that have been established by Providence Health Plan. Covered Services do NOT include Services for the inappropriate use of an Urgent Care facility, such as: services that do not require immediate attention, routine check-ups, follow-up care, and prescription drug requests.

Usual, Customary and Reasonable (UCR)

When a Service is provided by an In-Network Provider, UCR means charges based on the fee that 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 determined, in Providence Health Plan's reasonable discretion, based on the lesser of:

1. The fee a professional provider usually charges for a given Service;
2. A fee which falls within the range of usual charges for a given Service billed by most professional providers in the same locality or region who have similar training and experience;
3. A fee which is based upon a percentage of the Medicare allowable amount;
4. A fee which is prevalent or which would not be considered excessive in a particular case because of unusual circumstances; or
5. The fee determined by comparing charges for similar Services to a regional or national database adjusted to the geographical area where the Service was performed.

UCR charges do not include sales taxes, handling fees and similar surcharges, and such taxes, fees and surcharges are not covered expenses.

Virtual Visit

Virtual Visit means a visit with a Provider using secure internet technology:

- Phone and Video Visit:
  Phone and Video Visit means a Medically Necessary and appropriate consultation through phone and video with an In-Network or Out-of-Network Provider using Providence Health Plan approved secure technology. A Phone and Video Visit must relate to the treatment of a covered illness or injury (see also section 4.3.2).

Women's Health Care Provider

Women's Health Care Provider means an obstetrician or gynecologist, some Primary Care Providers (if they are licensed to provide obstetrical services), physician assistant specializing in women's health, advanced registered nurse practitioner specialist in women's health, certified nurse midwife, or licensed direct entry midwife practicing within the applicable lawful scope of practice.

16. NON-DISCRIMINATION STATEMENT

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: 711 :TTY).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

ATTENTION: Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)

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 Clackamas County self-funded Employee Health Benefit Plan, Clackamas County Peace Officers Association Open Option Grandfathered 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 Clackamas County'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, 2021.

By: _____

Printed Name: _____

Title: _____

Company: _____

Date: _____

Administered by

PROVIDENCE
Health Plan

Our Mission

As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Our Values

Compassion | Dignity | Justice | Excellence | Integrity

Questions? We're here to help.

Speak to one of our Customer Service representatives at 503-574-7500 or 800-878-4445 (TTY: 771); 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.

©2020 Providence Health Plan. All rights reserved.

Clackamas Co POA Open Option GF SPD
Effective January 01, 2021
Administered by Providence Health Plan

2021 Summary Plan Description

Peace Officers Association Personal Option Grandfathered

TABLE OF CONTENTS

1. INTRODUCTION 1

1.1 KEY FEATURES OF YOUR CLACKAMAS COUNTY PEACE OFFICERS ASSOCIATION PERSONAL OPTION GRANDFATHERED PLAN 2

1.2 GRANDFATHERED PLAN NOTICE 3

2. WELCOME TO PROVIDENCE HEALTH PLAN 4

2.1 CLACKAMAS COUNTY PEACE OFFICERS ASSOCIATION PERSONAL OPTION GRANDFATHERED PLAN 4

2.2 SUMMARY PLAN DESCRIPTION 4

2.3 CUSTOMER SERVICE 5

2.4 REGISTERING FOR A MYPROVIDENCE ACCOUNT 5

2.5 YOUR MEMBER ID CARD 5

2.6 PROVIDENCE NURSE ADVICE LINE 6

2.7 WELLNESS BENEFITS 6

2.8 PRIVACY OF MEMBER INFORMATION 8

3. HOW TO USE YOUR PLAN 10

3.1 IN-NETWORK PROVIDERS 10

3.1.1 Nationwide Network of In-Network Providers 10

3.1.2 Choosing an In-Network Provider 10

3.1.3 Indian Health Services Providers 10

3.2 THE ROLE OF A PRIMARY CARE PROVIDER 11

3.2.1 Primary Care Providers 11

3.2.2 Established Patients with Primary Care Providers 11

3.2.3 Selecting a New Primary Care Provider 11

3.2.4 Changing Your Primary Care Provider 12

3.2.5 Office Visits 12

3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS 12

3.4 MOVING INTO OR OUT OF THE SERVICE AREA 14

3.5 OUT-OF-AREA DEPENDENTS 14

3.5.1 Out-of-Area Dependent Enrollment 15

3.5.2 Out-of-Area Dependent Coverage 15

3.5.3 Out-of-Area Dependents and Change of Status 15

3.5.4 Out-of-Area Dependents Prior Authorization 15

3.6 NOTICE OF PROVIDER TERMINATION 15

3.7 PRIOR AUTHORIZATION 16

3.8 TRAVEL EXPENSE REIMBURSEMENT 17

3.9 MEDICAL COST MANAGEMENT 18

3.9.1 Coverage of New Technology and New Application of Existing Technology 18

3.10 MEDICALLY NECESSARY SERVICES 19

3.11 APPROVED CLINICAL TRIALS 20

3.12 HOW BENEFITS ARE APPLIED 20

3.13 OUT-OF-POCKET MAXIMUMS 20

3.13.1 Understanding Out-of-Pocket Maximums 20

4. COVERED SERVICES 22
4.1 PREVENTIVE SERVICES 22
4.1.1 Physical Examinations and Well-Baby Care 23
4.1.2 Immunizations and Vaccinations 23
4.1.3 Prostate Cancer Screening Exams 24
4.1.4 Colorectal Cancer Screening Exams 24
4.1.5 Preventive Services for Members with Diabetes 24
4.1.6 Diabetes Self-Management Education Program 24
4.1.7 Nutritional Counseling 24
4.1.8 Tobacco Use Cessation Services 25
4.2 WOMEN'S PREVENTIVE HEALTH CARE SERVICES 25
4.2.1 Gynecological Examinations 25
4.2.2 Mammograms 25
4.2.3 Breastfeeding Counseling and Support 25
4.2.4 Family Planning Services 25
4.3 PROVIDER SERVICES 26
4.3.1 Office Visits, Inpatient and Outpatient Hospital Visits, and Home Visits 26
4.3.2 Virtual Visits 26
4.3.3 E-mail Visits 26
4.3.4 Telemedical Services 27
4.3.5 Allergy Shots, Allergy Serums, Injectable and Infused Medications 28
4.3.6 Administration of Anesthesia and Surgical Procedures 28
4.3.7 Immediate Care 28
4.3.8 Retail Health Clinic 28
4.4 DIAGNOSTIC SERVICES 29
4.4.1 Diagnostic Pathology, Radiology Tests, High Tech Imaging and Diagnostic Procedures 29
4.4.2 Sleep Study Services 29
4.5 EMERGENCY CARE AND URGENT CARE SERVICES 29
4.5.1 Emergency Care 29
4.5.2 Emergency Medical Transportation 31
4.5.3 Emergency Eye Care Services 31
4.5.4 Emergency Detoxification Services 31
4.5.5 Urgent Care 31
4.6 INPATIENT HOSPITAL AND SKILLED NURSING FACILITY SERVICES 32
4.6.1 Inpatient Hospital Services 32
4.6.2 Skilled Nursing Facility 33
4.6.3 Inpatient Rehabilitative Care 33
4.6.4 Inpatient Habilitative Care 33
4.6.5 Observation Care 34
4.7 OUTPATIENT SERVICES 34
4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy, and Multidisciplinary Pain Management Programs 34
4.7.2 Outpatient Rehabilitative Services 34

4.7.3 Outpatient Habilitative Services 35
4.8 MATERNITY SERVICES 35
4.9 MEDICAL SUPPLIES, MEDICAL APPLIANCES, PROSTHETIC AND ORTHOTIC DEVICES AND DURABLE MEDICAL EQUIPMENT (DME) 36
4.9.1 Medical Supplies (including Diabetes Supplies) 37
4.9.2 Medical Appliances 37
4.9.3 Prosthetic and Orthotic Devices 37
4.9.4 Durable Medical Equipment (DME) 38
4.10 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES 38
4.10.1 Mental Health Services 38
4.10.2 Applied Behavior Analysis 38
4.10.3 Substance Abuse Services 39
4.11 HOME HEALTH AND HOSPICE CARE 40
4.11.1 Home Health Care 40
4.11.2 Hospice Care 40
4.12 OTHER COVERED SERVICES 41
4.12.1 Genetic Testing and Counseling Services 41
4.12.2 Inborn Errors of Metabolism 41
4.12.3 Podiatry/Foot Services 41
4.12.4 Reconstructive Surgery 42
4.12.5 Reconstructive Breast Surgery 42
4.12.6 Restoration of Head/Facial Structures; Limited Dental Services 42
4.12.7 Temporomandibular Joint (TMJ) Services 43
4.12.8 Self-Administered Chemotherapy 43
4.12.9 Gender Dysphoria 44
4.12.10 Elective Sterilization 44
4.12.11 Hearing Loss Services 44
4.12.12 Wigs 45
4.13 HUMAN ORGAN/TISSUE TRANSPLANTS 45
4.13.1 Covered Services 45
4.13.2 Benefits for Transplant Facility Services Provided to the Organ Recipient 46
4.13.3 Benefits for Outpatient Medications 47
4.13.4 Benefits for Physician/Provider Services Provided to the Organ Recipient 47
4.13.5 Transplant Prior Authorization 47
4.13.6 Transplant Exclusions 47
4.14 PRESCRIPTION DRUG BENEFIT 48
4.14.1 Using Your Prescription Drug Benefit 48
4.14.2 Use of Out-of-Network Pharmacies 49
4.14.3 Prescription Drug Formulary 50
4.14.4 Generic and Brand-Name Prescription Drugs 50
4.14.5 Prescription Drug Quantity 50
4.14.6 Participating Mail-Order and Preferred Retail Pharmacies 51
4.14.7 Prescription Drug Limitations 51
4.14.8 Prescription Drug Exclusions 52
4.14.9 Prescription Drug Disclaimer 53

4.15 CHIROPRACTIC CARE BENEFIT 53
4.15.1 Chiropractic Care Providers 53
4.15.2 Chiropractic Care Services 54
5. EXCLUSIONS 55
6. CLAIMS ADMINISTRATION 61
6.1 CLAIMS PAYMENT 61
6.1.1 Timely Submission of Claims 62
6.1.2 Right of Recovery 63
6.2 COORDINATION OF BENEFITS 63
6.2.1 Definitions Relating to Coordination of Benefits 63
6.2.2 Order of Benefit Determination Rules 65
6.2.3 Effect on the Benefits of This Plan 67
6.2.4 Right to Receive and Release Needed Information 67
6.2.5 Facility of Payment 67
6.2.6 Right of Recovery 68
6.2.7 Coordination with Medicare 68
6.3 THIRD-PARTY LIABILITY/SUBROGATION 68
6.3.1 Third-Party Liability/Subrogation and How It Affects You 69
6.3.2 Proceeds of Settlement or Recovery 70
6.3.3 Suspension of Benefits and Reimbursement 70
6.3.4 Special Rules for Motor Vehicle Accident Cases 71
7. PROBLEM RESOLUTION 72
7.1 INFORMAL PROBLEM RESOLUTION 72
7.2 MEMBER GRIEVANCE AND APPEAL 72
7.2.1 Your Grievance and Appeal Rights 73
7.2.2 Internal Grievance or Appeal 74
7.2.3 External Review 74
7.2.4 How to Submit Grievances or Appeals and Request Appeal Documents 75
8. ELIGIBILITY AND ENROLLMENT 76
8.1 EMPLOYEE ELIGIBILITY AND ENROLLMENT 76
8.1.1 Employee Eligibility Date 76
8.1.2 Employee Effective Date 76
8.1.3 Employee Enrollment 76
8.2 DEPENDENT ELIGIBILITY AND ENROLLMENT 76
8.2.1 Eligibility Date 76
8.2.2 Additional Requirements for Eligible Family Dependent Coverage 76
8.2.3 Eligible Family Dependent Enrollment 77
8.2.4 Newborn Eligibility and Enrollment 77
8.2.5 Open Enrollment Period 77
8.2.6 Changes in Eligibility 77
8.2.7 Members No Longer Eligible for Coverage 77
8.3 SPECIAL ENROLLMENT PERIODS 78
8.3.1 Loss of Other Coverage 78
8.3.2 New Dependents 79

8.3.3 Court Orders 79
8.3.4 Premium Assistance 79
8.4 LEAVE OF ABSENCE AND LAYOFFS 80
9. TERMINATION OF MEMBER COVERAGE 81
9.1 TERMINATION DATES 81
9.2 TERMINATION AND RESCISSION OF COVERAGE DUE TO FRAUD OR ABUSE 81
9.3 NON-LIABILITY AFTER TERMINATION 81
9.4 DISENROLLMENT FROM THIS PLAN 82
9.5 NOTICE OF CREDITABLE COVERAGE 82
9.6 CLACKAMAS COUNTY'S RIGHT TO TERMINATE OR AMEND PLAN 82
10. CONTINUATION OF GROUP MEDICAL BENEFITS 83
10.1 COBRA CONTINUATION COVERAGE 83
10.1.1 Subscriber's Continuation Coverage 83
10.1.2 Spouse's or Domestic Partner's Continuation Coverage 83
10.1.3 Dependent's Continuation Coverage 83
10.1.4 Notice Requirements 84
10.1.5 Type of COBRA Continuation Coverage 84
10.1.6 COBRA Election Rights 84
10.1.7 COBRA Premiums 84
10.1.8 Length of COBRA Continuation Coverage 84
10.1.9 Extension of Continuation Period 85
10.1.10 Trade Act of 2002 86
10.1.11 When COBRA Continuation Coverage Ends 86
11. MEMBER RIGHTS AND RESPONSIBILITIES 87
11.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES 87
11.2 INFORMATION FOR NON-ERISA MEMBERS (PARTICIPANTS) 88
12. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO) 90
12.1 DEFINITIONS 90
12.2 NOTICE UPON RECEIPT OF ORDER 90
12.3 NOTICE OF DETERMINATION 90
12.4 ENROLLMENT OF ALTERNATE RECIPIENT 91
12.5 COST OF COVERAGE 91
12.6 REIMBURSEMENT OF PLAN EXPENSES 91
12.7 STATUS OF ALTERNATE RECIPIENT 91
12.8 TREATMENT OF NATIONAL MEDICAL SUPPORT NOTICE 92
13. GENERAL PROVISIONS 93
13.1 CONFLICTS OF PROVISIONS 93
13.2 CONTROLLING STATE LAW 93
13.3 DUPLICATING PROVISIONS 93
13.4 FAILURE TO PROVIDE INFORMATION OR PROVIDING INCORRECT OR INCOMPLETE INFORMATION 93
13.5 GENDER AND NUMBER 93
13.6 HEADINGS 93
13.7 LEGAL ACTION 94

13.8 LIMITATIONS AND PROVISIONS 94
13.9 MEMBER RESPONSIBILITY 94
13.10 MEMBERSHIP ID CARD 94
13.11 NON-TRANSFERABILITY OF BENEFITS 94
13.12 NO GUARANTEE OF EMPLOYMENT 94
13.13 NO RECOURSE FOR ACTS OF PROVIDERS 95
13.14 NON-WAIVER 95
13.15 NOTICE 95
13.16 NOTICE REQUIRED FOR REIMBURSEMENT AND PAYMENT OF CLAIM 95
13.17 PAYMENT OF BENEFITS TO PERSONS UNDER LEGAL DISABILITY 95
13.18 PHYSICAL EXAMINATION AND AUTOPSY 96
13.19 PROFESSIONAL REVIEW AND RIGHT TO EXAMINE RECORDS 96
13.20 REQUIRED INFORMATION TO BE FURNISHED 96
13.21 RIGHT OF RECOVERY 96
13.22 SEVERABILITY 96
13.23 STATE MEDICAID BENEFITS RIGHTS 97
13.24 SUGGESTIONS 97
13.25 VETERANS' RIGHTS 97
13.26 WORKERS' COMPENSATION INSURANCE 97
14. PLAN ADMINISTRATION 98
14.1 TYPE OF ADMINISTRATION 98
14.2 PLAN INFORMATION 98
14.3 PLAN DATES 98
14.4 PLAN SPONSOR INFORMATION 98
14.5 ADMINISTRATIVE SERVICES PROVIDED BY 98
14.6 AGENT FOR SERVICE OF LEGAL PROCESS 98
14.7 ADMINISTRATIVE SERVICES 99
14.7.1 Complete Allocation of Fiduciary Responsibilities 99
14.8 ENGAGEMENT OF ADVISORS 99
14.9 INDEMNIFICATION 99
14.10 AMENDMENT OR TERMINATION OF PLAN 99
14.10.1 Right to Amend or Terminate 99
14.10.2 Manner of Action 100
14.10.3 Effect on Benefits 100
14.11 PROTECTED HEALTH INFORMATION 100
14.11.1 Disclosure 100
14.11.2 Security 101
15. DEFINITIONS 102
16. NON-DISCRIMINATION STATEMENT 115

1. INTRODUCTION

Statement from Plan Sponsor

Clackamas County has designed this Plan in cooperation with Providence Health Plan. The benefits under the Plan are provided by Clackamas County on a self-insured basis. Clackamas County 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.

Clackamas County Benefits & Wellness: 503-655-8550

Customer Service Quick Reference Guide:

Medical 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 Chemical Dependency 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)
Providence Resource Line To find a care provider or to register for Providence classes	503-574-6595
myProvidence Help Desk	503-216-6463 877-569-7768 (toll-free)
LifeBalance	503-234-1375 888-754-LIFE (toll-free) www.LifeBalanceProgram.com
Provider Directory	ProvidenceHealthPlan.com/findaprovider

1.1 KEY FEATURES OF YOUR CLACKAMAS COUNTY PEACE OFFICERS ASSOCIATION PERSONAL OPTION GRANDFATHERED PLAN

- Some capitalized terms have special meanings. Please see section 15, Definitions.
- In this Summary Plan Description, Providence Health Plan and Clackamas County 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; and
  - Providence Health Plan's national network of In-Network Providers.
- Covered Services must be obtained from In-Network Providers, with the following exceptions:
  - Emergency Services and Urgent Care Services, as specified in section 4.5;
  - Covered Services received by an enrolled Out-of-Area Dependent, as specified in section 3.5.2; and
  - Covered Services delivered by an Out-of-Network Provider when those Services have been approved in advance through the Prior Authorization procedures specified in section 3.7.
- 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 and our national In-Network Providers 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 3.7.**
- Coverage limitations and exclusions apply to certain Services, as stated in sections 3, 4, 5 and the Benefit Summary.
- 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 Plan documents. 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 or amendments that accompany these documents, the agreement between Providence Health Plan and the Plan Sponsor (if any), 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) Providence Health Plan/ Plan Sponsor agreement, (3) Summary Plan Description, (4) Benefit Summary(ies), and (5) applicable Providence Health Plan's policies.

1.2 GRANDFATHERED PLAN NOTICE

This Employer Group believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA). As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of PPACA that apply to other Plans, for example, the requirement for the coverage of certain preventive health care services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in PPACA, for example, the elimination of the lifetime maximum benefit.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the employer or human resources department.

Non-ERISA plans: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.
Thank you for choosing Providence Health Plan. We look forward to meeting your health care needs. 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 Clackamas County Peace Officer Association Employees and their Dependents.

2. WELCOME TO PROVIDENCE HEALTH PLAN

Thank you for choosing Providence Health Plan. We look forward to meeting your health care needs. 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 Clackamas County Peace Officer Association Employees and their Dependents.

2.1 CLACKAMAS COUNTY PEACE OFFICERS ASSOCIATION PERSONAL OPTION GRANDFATHERED PLAN

Your Plan allows you to receive Covered 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 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 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 for what you owe later. 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 Clackamas County. 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 15. 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:

- **Clackamas County Peace Officers Association Personal Option Grandfathered Plan Medical Benefit Summary** and any other Benefit Summary documents issued with this Plan. These documents are available at www.ProvidenceHealthPlan.com when you register for a myProvidence account as explained in section 2.4. Benefit Summaries detail your Copayments and Coinsurance for Covered Services and also provide 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 or check with your Employer's human resource department to obtain a hard copy of the directory.

If you need 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.
- 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. 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. If you have questions or need assistance registering for or accessing an existing account, contact myProvidence customer service at 877.569.7768.

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 confer 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:

- Visit your health care provider or facility.
- Register online for your myProvidence account.
- Call for Mental Health/Substance Abuse 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 recorded message, a registered nurse will come on line to assist you.

Please have your Member ID Card available when you call.

2.7 WELLNESS BENEFITS

Providence Resource Line — 503-574-6595; 800-562-8964

Providence Resource Line is your connection to information and services on classes, self-help materials, tobacco-use cessation services, and for referrals to Providence Health Plan In-Network Providers and to Providence Health & Services programs and services. Services and health-education vary by geographic service area.

Health Education

Providence Health Plan offers a wide variety of classes to help you achieve healthy lifestyle and wellness goals. We can assist you in learning to eat right and manage your weight, prepare for childbirth and much more. If you have diabetes, health education classes also are available (see section 4.1.6, for further information).

Providence Health Plan Members receive discounts on health education classes. Your costs, services and the health education classes available may vary by geographic-service area. For more information on classes available in your area, call the Providence Resource Line at 503-574-6595 or 800-562-8964 or visit www.providence.org/classes.

Health Coaching

Providence Health Plan offers Members free coaching support for weight loss, diabetes prevention, nutrition, stress management, exercise, sleep and tobacco cessation. For more information on health coaching, call 503-574-6000 (TTY: 711) or 888-819-8999 or visit www.ProvidenceHealthPlan.com/healthcoach.

Care Management
Providence Care Management provides Members with information and assistance with healthcare navigation, as well as managing chronic conditions from a Registered Nurse Care Manager.

You can access these Services by calling 800-662-1121 or e-mailing caremanagement@providence.org.

Tobacco Use Cessation
Your Wellness Benefits include access to tobacco-use cessation programs provided through our Providence Health & Services Hospitals as well as through Quit for Life. These programs address tobacco dependence through a clinically proven, comprehensive approach to tobacco-use cessation that treats all three aspects of tobacco use – physical addiction, psychological dependence and behavioral patterns. (See section 4.1.8 regarding coverage for tobacco-use cessation Services).

More information about our Tobacco-Use Cessation programs can be found online at http://www.providence.org/healthplans/members/healthbalance/smokingcessation.aspx, or by calling 503-574-6595 or 800-562-8964.

Quit for Life can be reached at 866-QUIT-4-LIFE (784-8454), 5 a.m. through 9 p.m. (Pacific Time), seven days a week.

Wellness information on our website — www.ProvidenceHealthPlan.com
Visit Providence Health Plan online at www.ProvidenceHealthPlan.com for medical information, class information, information on extra values and discounts and a wide array of other information described with your good health in mind. You also may set up your own myProvidence account to gain access to your specific personal health plan information. See Registering for a myProvidence account, section 2.4, for more details.

LifeBalance — 503-234-1375 or 888-754-LIFE www.LifeBalanceProgram.com
This program offers exclusive discounts to Providence Health Plan Members on a wide variety of health and wellness programs, as well as recreational, cultural and wellness activities. You can save on professional instruction, fitness club memberships, yoga classes, and much more. You also have access to discounted events, such as white-water rafting, ski trips, theater nights, and sporting events.

Learn more by visiting the LifeBalance website at www.LifeBalanceProgram.com or calling LifeBalance at 503-234-1375 or 888-754-LIFE. Please have your Providence Health Plan Member ID Card ready when you request LifeBalance discounts.

Assist America
Your wellness benefits include access to travel assistance services and identity theft protection services.

Travel Assistance Services include emergency logistical support to members traveling internationally or people traveling 100 miles from home. Learn more by visiting www.assistamerica.com or calling Assist America at 609-986-1234 or 800-872-1414.

Assist America also provides identity theft protection services 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. Please have your Providence Health Plan Member ID card ready, 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 https://healthplans.providence.org/members/rights-notices or by calling Customer Service.

Appointment of Authorized Representative

You are entitled to appoint an individual to act as your authorized representative to pursue any claim you have for benefits. To ensure privacy and to address other issues, Providence's policy on Appointment of Authorized Member Representatives, and the form for doing so, may be accessed through our website at https://healthplans.providence.org/members/understanding-plans-benefits/benefit-basics/forms/. The policy does not apply to an attorney at law retained by you directly to represent your interests with respect to your benefits, but does apply to attorneys who represents a medical service provider whose services are a part of the claim in issue.

Confidentiality and your Employer

In accordance with the federal privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), Providence Health Plan will not disclose a Member's protected health information (PHI) to the Employer or any agent of the Employer unless requested for the HIPAA allowed purpose of the Employer's obtaining bids from other health plans for further health coverage or for the Employer's modifying, amending, or terminating any benefit under the health plan.

Providence Health Plan may disclose a Member's PHI to an employer or any agent of the Employer if the disclosure is:

1. In compliance with the applicable provisions of HIPAA; and
2. Due to a HIPAA compliant authorization, the Member has completed to allow the Employer access to the Member's PHI; or
3. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer. The details of this required certification can be reviewed at https://healthplans.providence.org/about-us/privacy-notices-policies/protected-health-information-and-your-employer/.

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. HOW TO USE YOUR PLAN

Our goal is maintaining your health by promoting wellness and preventive care. We encourage you to work closely with one provider, your 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 section 4 of this Summary Plan Description.

3.1 IN-NETWORK PROVIDERS

Providence Health Plan has contractual arrangements with certain physicians/providers, hospitals and facilities. Our agreements with these "In-Network Providers" enable you to receive quality health care for a reasonable cost.

For Services to be covered, 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.

3.1.1 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 of Oregon and southwest Washington.

3.1.2 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 the Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider. If you do not have access to our website, please call Customer Service to request In-Network Provider Information.

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 3.7.

3.1.3 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 St., Ste. 800
Portland, OR 97209
Telephone: 503-414-5555

3.2 THE ROLE OF A PRIMARY CARE PROVIDER

To encourage optimum health, we promote wellness and preventive care. We also believe wellness and overall health is enhanced by working closely with one physician or provider – your 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 an In-Network Primary Care Provider as soon as possible.

3.2.1 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 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 screenings, 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: In-Network Primary Care Providers have a special agreement with us to serve as a case manager for your care. This means not all of our In-Network Providers with the specialties listed above are In-Network Primary Care Providers. Please refer to the Provider Directory, available online, for a listing of designated In-Network Primary Care Providers or call your Customer Service team to request a hard copy.

3.2.2 Established Patients with Primary Care Providers

If you and your family already see a provider, you may want to check the provider directory to see if your provider is an In-Network Primary Care Provider for Providence Health Plan. If your provider is participating with us, let their office know you are now a Providence Health Plan Member.

3.2.3 Selecting a New Primary Care Provider

We recommend 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 they are 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.

3.2.4 Changing Your Primary Care Provider

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.

3.2.5 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 the Provider Directory, available online at ProvidenceHealthPlan.com/findaprovider, or call Customer Service to choose a specialist who 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. (For certain Plans, there is a Member Copayment for specialist visits instead of a Coinsurance. If you are on one of these Plans, you will need to pay your Member Copayment at the time of your visit. Please check your Benefit Summary for your specific coverage information.)

Chiropractic Care Providers

This Plan includes coverage for specified chiropractic services. See section 4.15 and your Benefit Summary.

3.3 SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS

Providence Health Plan may approve and provide reimbursement for Out-of-Network Qualified Practitioners and facilities. Benefits for Covered Services by an Out-of-Network provider will be provided as shown in the Benefit Summary when we determine in advance,

in writing, that the Out-of-Network Provider possesses unique skills which are required to adequately care for you and are not available from In-Network Providers.

Under no circumstances (with the exception of Emergency and Urgent Care) will we cover Services received from an Out-of-Network Provider/Facility unless we have Prior Authorized the Out-of-Network Provider/Facility and the Services received.

IMPORTANT NOTE: Your Plan only pays for Covered Services received from Prior Authorized Out-of-Network Providers at Usual, Customary, and Reasonable rates (UCR) (see Section 15, Definitions). If the approved, Prior Authorized 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 Copayment, or Coinsurance for which you may be responsible, and does not accrue to your Out-of-Pocket Maximum.

If you choose to receive Covered Services from an approved, Prior Authorized Out-of-Network Provider, those Services are still subject to the terms of this Summary Plan Description. Your 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.

It is important for you to understand that Providence Health Plan has not assessed the approved, Prior Authorized Out-of-Network 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.

Payment for Out-of-Network Physician/Provider Services (UCR)

If the Services provided are Medically Necessary Covered Services, we will provide payment to Out-of-Network Providers according to Usual, Customary and Reasonable (UCR) charges. UCR charges do not include sales taxes, handling fees and similar surcharges; such taxes, fees and surcharges are not covered expenses. Charges which exceed UCR are the Member's responsibility and are not applied to the Out-of-Pocket Maximum. See section 15 for the definition of UCR.

You will be responsible for costs that are not covered or allowed by your Out-of-Plan benefits as shown in the following example (amounts shown are only estimates of what may apply).

	Provider's Status	
Item	In-Network	Out-of-Network
Provider's standard charges	$100	$100
Allowable charges under this Plan	$80 (contracted)	$80 (if that is UCR)
Plan benefits (for this example only)	$64 (if 80% benefit)	$56 (if 70% benefit)
Balance you owe	$16	$24
Additional amount that the provider may bill to you	$-0-	$20 ($100 minus $80)
Total amount you would pay	$16	$44 ($24 plus $20)

Thus, you may incur significantly larger out-of-pocket costs, perhaps a multiple of what would have applied, if you use Out-of-Network Physicians or Providers.

Payment for 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-Plan 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-Plan provider.

3.4 MOVING INTO OR OUT OF THE SERVICE AREA

If you or a Family Member permanently moves into or out of the Service Area, you must immediately notify us and your Employer as such a move may affect your benefits or coverage under this Personal Option Plan. We will determine how this move affects your coverage and will inform you of any changes. If you have Dependent(s) who move in or out of our Service Area, a Change of Status form for those Dependent(s) must be completed and returned to us as soon as possible. This form can be obtained from us or from your Employer. See section 8.2.6 for more information.

3.5 OUT-OF-AREA DEPENDENTS

Dependents of a subscriber on a Personal Option Plan who live outside the Providence Health Plan Service Area (including dependents who are away at school) are eligible to become Out-of-Area Dependent Members. See "Definitions" section 15, for the definition of "Eligible Family Dependent" and "Out-of-Area Dependent." This section discusses how Enrolled Out-of-Area Dependent Personal Option Plan Members obtain covered services through Providence Health Plan's enrolled Out-of-Area Dependent benefit.

3.5.1 Out-of-Area Dependent Enrollment

To apply for Personal Option Out-of-Area Dependent benefits, complete an Out-of-Area Dependent Enrollment form, available from your Customer Service team. **If you do not complete an Out-of-Area Dependent Enrollment form, your Out-of-Area Dependent will not be covered for Out-of-Area Dependent benefits.**

3.5.2 Out-of-Area Dependent Coverage

When you enroll for Out-of-Area Dependent coverage, we will send you an Out-of-Area Dependent Benefit Summary. As stated in your Benefit Summary, a Dependent with Out-of-Area benefits may see any provider, in or out of the Service Area. Please refer to your Out-of-Area Dependent Benefit Summary for detailed Coinsurance or Copayment and annual Out-of-Pocket Maximum information. (For Out-of-Area Dependents who are covered by a government sponsored health plan of a county other than the United States, coverage under this Personal Option Out-of-Area Dependent plan will be secondary and will not replace or duplicate coverage available under the government sponsored plan.) Our payment is based on usual, customary and reasonable (UCR) charges. Charges which exceed UCR charges are your responsibility.

You must purchase your prescription drugs at one of our nationwide Participating Pharmacies (see section 4.14.1). A list of our Participating Pharmacies is available online at www.ProvidenceHealthPlan.com. You also may contact Customer Service if you need help locating a Participating Pharmacy near you or when you are away from your home. See your Benefit Summary for details on your Copayment and Coinsurance, if applicable, and on how to use this benefit.

3.5.3 Out-of-Area Dependents and Change of Status

Enrolled Out-of-Area Dependents may change to In-Area or Out-of-Area status by contacting us and completing a status change enrollment form. The change will be effective the date you specify or if no date is specified, on the first of the month following our receipt of the enrollment form. Retroactive changes are limited to 30 days.

3.5.4 Out-of-Area Dependents Prior Authorization

Enrolled Out-of-Area Dependents are responsible for obtaining Prior Authorization from Providence Health Plan prior to receiving certain services from Out-of-Network Providers. For further information about Prior Authorization, including a list of these Covered Services and how to obtain Prior Authorization, see section 3.7.

You must contact us to obtain Prior Authorization for specified Covered Services if the Services are to be received from an Out-of-Network Provider. See section 3.7.

3.6 NOTICE OF PROVIDER TERMINATION

When an In-Network Provider whose contract of participation with us terminates, we will notify those Members who we know are under the care of the terminated provider within 10 days of the termination date or of our knowledge of the termination date.

3.7 PRIOR AUTHORIZATION

While Prior Authorization is a requirement for coverage of certain Services under this Plan, Prior Authorization is not a treatment directive. The actual course of medical treatment that a Member chooses remains strictly a matter between the Member and the 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 Medical Necessity.

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. You or your Out-of-Network provider must contact us to obtain Prior Authorization. See section 3.3 for additional information about Out-of-Network Providers.

Services requiring Prior Authorization:

- All inpatient admissions to a Hospital (not including emergency room care), Skilled Nursing Facility or a rehabilitation facility, all emergency hospitalizations (we need to be notified within 48 hours, or as soon as reasonably possible), and all Hospital and birthing center admissions for maternity/delivery Services.
- All outpatient surgical procedures.
- Anesthesia Care with Diagnostic Endoscopy.
- All Travel Expense Reimbursement, as provided in section 3.8.
- All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services for Mental Health, and Substance Abuse, as provided in sections 4.10.1 and 4.10.2.
- All Applied Behavior Analysis, as provided in section 4.10.3.
- All Human Organ/Tissue Transplant Service, as provided in 4.13.
- All Restoration of Head/Facial Structures; Limited Dental Services, as provided in section 4.12.6.
- All Temporomandibular Joint (TMJ) Services, as provided in section 4.12.7.
- All High Tech Imaging, including PET, CT, CTA, MRI and MRA, Nuclear Cardiac Study Services, and echocardiography Services, as provided in section 4.4.1.
- All Sleep Study Services, as provided in section 4.4.2.
- Certain Home Health Care Services, as provided in section 4. 11.1.
- Certain Hospice Care Services, as provided in section 4.11.2.
- Certain Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment, as provided in section 4.9.
- Certain outpatient services including, but not limited to, neurodevelopmental therapy, neurological testing, and botulinum therapies.
- All outpatient hospitalization and anesthesia for dental Services as provided in section 4.12.6.
- All Genetic Testing Services, as provided in section 4.12.1.

- Certain medications, including certain immunizations, received in your Provider's office, as provided is sections 4.3.5 and 4.1.2.
- Certain prescription drugs specified in our Formulary, as provided in section 4.14.1.
- Certain infused Prescription Drugs administered in a hospital-based infusion center, as provided in section 4.7.1.

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-Plan 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 section 3.3, a 50% **penalty**, not to exceed $2,500 for each Covered Service, will be applied to the claim.

Should Providence Health Plan 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 Out-of-Pocket Maximum shown in the Benefit Summary.

3.8 TRAVEL EXPENSE REIMBURSEMENT

Subject to Prior Authorization, if you are unable to locate an In-Network Provider to provide Medically Necessary Covered Services for your specific condition within 50 miles of your home, the Plan will reimburse your travel expense to the nearest In-Network Provider within 300 miles of your home. Reimbursement will be based on the federal medical mileage reimbursement rate in effect on the date of service. Travel expense reimbursement is limited to $1,500 per calendar year. If an overnight stay is required, food and lodging are reimbursable up to $150 per diem (per day). Per diem expenses apply to the $1,500 travel expenses reimbursement maximum. (Note: Transplant Covered Services include a separate travel expense benefit; see section 4.13.1).

3.9 MEDICAL COST MANAGEMENT

Coverage under this Plan is subject to the medical cost management protocols established by us to ensure the quality and cost effectiveness of Covered Services. Such protocols may include Prior Authorization, concurrent review, case management and disease management.

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 Services 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.

3.9.1 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 7.

3.10 MEDICALLY NECESSARY SERVICES

We believe our Members are entitled to comprehensive medical care within the standards of good medical practice. Providence Health Plan's medical directors and special committees of In-Network Providers determine which Services are Medically Necessary, as defined in section 15. 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 our guidelines. Obtaining confirmation of coverage from Providence Health Plan beforehand is always recommended.

3.11 APPROVED CLINICAL TRIALS

Benefits are provided for Covered Services directly related to a Member's participation in an Approved Clinical Trial offered through an In-Network provider.

Covered Services include the routine patient costs for items and services received from In-Network providers and facilities in connection with the Approved Clinical Trial, to the extent that the items and services are otherwise Covered Services under the Plan.

You may choose to participate in an Approved Clinical Trial offered through an Out-of-Network provider, however, coverage will only be provided for Medically Necessary services received In-Network in treatment of an illness or injury.

The following costs are excluded:

- The cost of the investigational item, device or service;
- The cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management;
- The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- The cost for any services received Out-of-Network.

The 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.

3.12 HOW BENEFITS ARE APPLIED

Benefits are subject to the following provisions, if applicable, as specified in the Benefit Summary:

1. The Copayment or Coinsurance amount; and
2. The benefit limits and/or maximums.

3.13 OUT-OF-POCKET MAXIMUMS

Your Plan has an Out-of-Pocket Maximum, as stated in your Benefit Summary.

3.13.1 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.

***Individual Out-of-Pocket Maximum*:** Individual Out-of-Pocket Maximum means the total amount of Copayments and Coinsurance that a Member must pay in a Calendar Year, as shown in the Benefit Summary, before the Plan begins to pay 100% for Covered Services for that Member within that Calendar Year.

***Family Out-of-Pocket Maximum*:** Family Out-of-Pocket Maximum means the total amount of Copayments and Coinsurance that a family of three or more must pay in a Calendar Year, as shown in the Benefit Summary, before the Plan begins to pay 100% for Covered Services for enrolled Family Members. When the combined Copayment and Coinsurance expenses of enrolled Family Members meet the family Out-of-Pocket Maximum, all remaining individual

Out-of-Pocket Maximums will be waived for the family for that Calendar Year.

Note: Once any 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 by this Plan;
- Services not covered because Prior Authorization was not obtained, as required in section 3.5;
- Services in excess of any maximum benefit limit;
- Fees in excess of the Usual, Customary and Reasonable (UCR) charges;
- Copayments or Coinsurance for a Covered Service if indicated in any Benefit Summary as not applicable to the Out-of-Pocket Maximum; and
- Any penalties you must pay if you do not follow 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. COVERED SERVICES

This section describes Services that, when Medically Necessary and not otherwise excluded or limited, are covered under this Plan.

Please refer to your Benefit Summary for details of your specific coverage. You can view your Member materials by registering for a myProvidence account on our website at www.ProvidenceHealthPlan.com (see section 2.4). If Clackamas County modifies your benefits, you will be notified in writing of the changes.

You must use In-Network Providers to receive the Covered Services listed in this section, unless you are an Enrolled Out-of-Area Dependent or have received Prior Authorization to receive services from an Out-of-Network Provider.

Benefits are provided for preventive care and for the treatment of illness or injury when such treatment is Medically Necessary and provided by a Qualified Practitioner as described in this section and shown in the Benefit Summary.

4.1 PREVENTIVE SERVICES

Preventive Services are covered as shown in the Benefit Summary. For Women's Preventive Health Care Services, see section 4.2.

In accordance with the Patient Protection and Affordable Care Act of 2010 and related legislation, your Plan covers the following Services in full when received from In-Network Providers:

- Services rated "A" or "B" by the U.S. Preventive Services Task Force, http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children and adolescents as supported by the Health Resources and Services Administration; and
- Preventive care and screenings for women as supported by the Health Resources and Services Administration, http://www.hrsa.gov/womens-guidelines.

Note: Additional Plan provisions apply to some Services (e.g., routine physical examinations and well-baby care must be received from an In-Network Primary Care Provider, see section 4.1.1). If you need assistance understanding coverage for preventive Services under your Plan, please contact Customer Service at 503-574-7500.

4.1.1 Physical Examinations and Well-Baby Care

Periodic health exams and well-baby care Services are covered only when received from an In-Network Primary Care Provider. These services are covered as stated in your Benefit Summary. Your provider will determine which tests are necessary for your physical exam according to your medical history and your current health status. More frequent exams will be covered if your provider determines that they are necessary. Vision and hearing screening services are covered when performed during a periodic health examination or well-baby care examination. In order for a child to be eligible for benefits for routine newborn baby care, the child must be properly enrolled as outlined in section 8. Ancillary Services, such as immunizations, are covered at the specified benefit level when billed by the provider.

Recommended Guidelines:

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. The Plan will not cover this additional fee.

Covered Services do **NOT** include the following:

1. Services for laser surgery, radial keratotomy and any other surgery to correct myopia, hyperopia or stigmatic error, vision therapy, orthoptic treatment (eye exercises);
2. Services for routine eye and vision care, refractive disorders, eyeglass frames and lenses, contact lenses; and
3. Hearing aids, except as specified in section 4.12.11.

4.1.2 Immunizations and Vaccinations

Benefits for immunizations and vaccinations are provided in accordance with accepted medical practice. Visits to your Qualified Practitioner's office or Participating Pharmacy for immunizations or injections are subject to the Copayment or Coinsurance shown in the Benefit Summary. Some immunizations may require Prior Authorization, as listed in the Medical benefit drug prior authorization list available on our website at https://healthplans.providence.org/members/pharmacy-resources/Pages/default.aspx or by calling Customer Service.

Covered Services do not include immunizations or vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel.

4.1.3 Prostate Cancer Screening Exams

Benefits for prostate cancer screening examinations include a digital rectal examination and a prostate-specific antigen test, biennially for men 50 and older, or as recommended by a Qualified Practitioner for men designated high risk.

4.1.4 Colorectal Cancer Screening Exams

Benefits for colorectal cancer screening examinations for Members age 50 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 high risk are covered as recommended by the Qualified Practitioner.

For Members age 50 and older:

- All Services for colorectal cancer screenings and exams are covered in full.

For Members under age 50:

- 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.

4.1.5 Preventive Services for Members with Diabetes

Preventive Services benefits for Members diagnosed with either insulin dependent or non-insulin dependent diabetes mellitus include:

- A dilated retinal exam by a qualified eye care specialist every Calendar Year;
- A glycosylated hemoglobin (HbA1c) test; urine test to test kidney function; blood test for lipid levels as appropriate; visual exam of mouth and teeth (dental visits are not covered); foot inspection; and influenza vaccine by a Qualified Practitioner every Calendar Year; and
- A pneumococcal vaccine every five years.

4.1.6 Diabetes Self-Management Education Program

Benefits are paid in-full for diabetes self-management education programs associated with the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes as prescribed by a Qualified Practitioner. “Diabetes self-management program” means one program of assessment and training after diagnosis as well as assessment and training upon a material change of condition, medication or treatment. All services must be received from licensed providers and facilities, practicing within scope of license.

4.1.7 Nutritional Counseling

A maximum of two visits per Calendar Year are covered for nutritional counseling when Medically Necessary, as determined by the Qualified Practitioner. Fasting and rapid weight loss programs are not covered.

4.1.8 Tobacco Use Cessation Services

Coverage is provided for participation in a Providence Health Plan-approved, physician-recommended tobacco use cessation program that follows the United States Public Health Service guidelines. "Tobacco use cessation program" includes educational and medical treatment components such as, but not limited to, counseling, classes, nicotine replacement therapy and prescription drugs designed to assist Members in ceasing the use of tobacco products. A list of Providence Health Plan-approved programs is available online at www.ProvidenceHealthPlan.com (select "search" and enter "tobacco cessation") or by calling Customer Service at 503-574-7500 or 800-878-4445.

4.2 WOMEN'S PREVENTIVE HEALTH CARE SERVICES

Women may choose to receive Women's Preventive Health Care Services from a Primary Care Provider or a Women's Health Care Provider. Women's Health Care Providers include physicians specializing in obstetrics, some Primary Care Providers (if they are licensed to provide the services), physician assistants and advanced registered nurse practitioners, certified nurse midwives, and licensed direct entry midwives.

4.2.1 Gynecological Examinations

Benefits for gynecological examinations include breast, pelvic and Pap examinations once every Calendar Year or more frequently for women who are designated high risk. Family planning Services are separate (see section 4.2.4). Benefits also include follow-up exams for any medical conditions discovered during an Annual gynecological exam that require additional treatment.

4.2.2 Mammograms

Mammograms are covered for women over 40 years of age once every Calendar Year. If the Member is designated high risk, mammograms are covered as recommended by the Qualified Practitioner or Women's Health Care Provider.

4.2.3 Breastfeeding Counseling and Support

Coverage for lactation counseling is provided when Medically Necessary as determined by the Qualified Practitioner. Lactation Counseling Services must be received from licensed providers. Benefits include coverage in full for breast pump equipment and supplies when rented or purchased through In-Network Medical Equipment Providers.

4.2.4 Family Planning Services

Benefits include counseling, exams, and services for voluntary family planning.

Services and supplies are covered as required by the Patient Protection and Affordable Care Act of 2010 and related legislation; and include, but are not limited to:

- Intrauterine device (IUD) insertion and removal;
- Medical exams and consultation for family planning;
- Depo-Provera to prevent pregnancy;
- Diaphragm devices;
- Removal of implantable contraceptives; and

- Oral contraceptives (birth control pills) listed in our Formulary. FDA-approved women's prescription contraceptives: up to 3 months initial dispensing, then up to 12 months subsequent dispensing at any Participating Pharmacy.

Services are covered in full and must be received from In-Network Providers and Facilities. Oral contraceptives must be purchased at Participating Pharmacies.

For coverage of tubal ligation, see Elective Sterilization, section 4.12.10.

4.3 PROVIDER SERVICES

4.3.1 Office Visits, Inpatient and Outpatient Hospital Visits, and Home Visits

Office visits, inpatient and outpatient Hospital visits and home visits with a Qualified Practitioner are covered as shown in your Benefit Summary. Copayments and Coinsurances, as shown in your Benefit Summary, apply to all provider visits except those that: (a) are part of a course of maternity care; (b) are for conditions for which this Plan contains a separate and specific Copayment or Coinsurance amount; or (c) are ancillary to the visit and are billed by the Qualified Practitioner. Some services provided by your Qualified Practitioner during your visit may result in additional Member financial responsibility.

For example – You see your Primary Care Provider for an office visit and during your visit your provider swabs your throat for a throat culture. You would pay your office visit Copayment or Coinsurance and would also need to pay the Laboratory Services Copayment or Coinsurance for the throat culture. See your Benefit Summary for details.

Your Benefit Summary also lists different Copayments or Coinsurance that may apply for other specific services, such as allergy shots, maternity care, and diagnostic services. See your Benefit Summary for details.

If you are unable to keep a scheduled office appointment with your provider, please try to notify that office in advance. If not, you may be charged for the missed appointment. Providence Health Plan will not cover this expense.

4.3.2 Virtual Visits

The Plan provides coverage for the following types of Virtual Visits with In-Network Providers using secure internet technology:

- Phone and Video Visits: Phone and Video Visits are covered as shown in your Benefit Summary. All Phone and Video Visits must be Medically Necessary and received from In-Network Providers. Not all In-Network Providers are contracted with us to provide Phone and Video Visits. In-Network Providers who are authorized to provide Phone and Video Visits have agreed to use secure internet technology approved by us to protect your information from unauthorized access or release.

4.3.3 E-mail Visits

E-mail Visits are covered in full and must be received from In-Network Providers. Not all In-Network Providers offer E-mail Visits. Medical doctors (M.D.), doctors of osteopathy (D.O.), nurse practitioners (N.P.) and physician assistants (P.A.) are the only categories of providers 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 the Plan;
- 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 Abuse Covered Services (as provided in section 4.10).

4.3.4 Telemedical Services

Telemedical Services are covered at the applicable benefit level for the Covered Service, as shown in the Benefit Summary, had the Service been received in person provided that the Service:

- Is Medically Necessary;
- Is provided by a Qualified Practitioner;
- Is determined to be safely and effectively provided using synchronous two-way interactive video conferencing according to generally accepted health care practices and standards; and
- The application and technology used to provide the Telemedical Service meet all standards required by state and federal laws governing the privacy and security of protected health information.

For Members utilizing Telemedical Services for the treatment of diabetes where one of the participants is a representative of an academic health center, coverage is provided when Services are delivered through a two-way electronic communication. This includes, but is not limited to, video, audio, Voice over Internet Protocol, or transmission of telemetry, that

allows a health professional to interact with the Member, a parent or guardian of a Member, or another health professional on a Member's behalf, who is at an originating site.

4.3.5 Allergy Shots, Allergy Serums, Injectable and Infused Medications

Allergy shots, allergy serum, injectable medications, and total parenteral nutrition (TPN) received in your Provider's office are covered as shown in your Benefit Summary. Therapy and testing for treatment of allergies including, but not limited to, Services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment are covered only when such therapy or testing is approved by the American Academy of Allergy and Immunology, or the Department of Health and Human Services or any of its offices or agencies. Some injectable medications may require Prior Authorization, as listed in the Medical benefit drug prior authorization list available on our website at https://healthplans.providence.org/members/pharmacy-resources/Pages/default.aspx or by calling Customer Service. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. See section 4.7.1 for coverage of infusion at Outpatient Facilities.

4.3.6 Administration of Anesthesia and Surgical Procedures

Benefits include the administration of anesthesia and surgical procedures, including assistant surgeon and post-operative care.

4.3.7 Immediate Care

Immediate Care is an extension of your Primary Care Provider's office, and provides additional access to treatment you need right away for an illness or injury that is not life threatening. This includes, but is not limited to, minor sprains, minor cuts and burns, and ear, nose, and throat infections. Routine care, like periodic health exams and well-baby care, should be delayed until you can be seen by your Primary Care Provider.

Whenever you need immediate care or, call your Primary Care Provider first. Your Primary Care Provider or the provider-on-call is always available, day or night. They may either suggest that you be seen at your Primary Care Provider's office, or direct you to an immediate care center, Urgent Care, or emergency care facility. See section 4.5 for coverage of Emergency Care and Urgent Care Services.

Please be prepared to pay the Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are also responsible for the applicable Copayment/Coinsurance shown in the Benefit Summary for any ancillary Services received, such as lab tests and X-rays, billed by the Immediate Care Provider.

4.3.8 Retail Health Clinic

Coverage is provided as shown in the Benefit Summary for Covered Services obtained at Retail Health Clinics. Retail Health Clinics can provide diagnosis and treatment services for uncomplicated minor illnesses and injuries, like sore throats, ear aches, and sprains. Routine care, like periodic health exams and well-baby care, should be delayed until you can be seen by your Primary Care Provider. All Covered Services must be Medically Necessary and appropriate and received from Qualified Practitioners. Not all services are available at Retail Health Clinics.

4.4 DIAGNOSTIC SERVICES

Coverage is provided as shown in your Benefit Summary for Diagnostic Services.

4.4.1 Diagnostic Pathology, Radiology Tests, High Tech Imaging and Diagnostic Procedures

Benefits are as shown in the Benefit Summary and include inpatient and outpatient diagnostic pathology (lab), high tech imaging (such as PET, CT, MRI and MRA), radiology (X-ray) tests, echocardiography, and other Medically Necessary diagnostic procedures. Covered Services include contrast materials (dyes) that may be required for a diagnostic procedure.

4.4.2 Sleep Study Services

Benefits include coverage of Medically Necessary polysomnography (PSG). PSG is an overnight sleep test performed at home or in a sleep laboratory. The test is used to confirm a sleep disorder and to determine the appropriate treatment. Services must be Prior Authorized.

The following diagnostics are excluded: actigraphy, daytime nap polysomnography, cephalographic or tomographic X-rays for diagnosis or evaluation of an oral device, and acoustic pharyngometry.

4.5 EMERGENCY CARE AND URGENT CARE SERVICES

Benefits for Emergency Services and Urgent Care Services are provided as described below and shown in your Benefit Summary. Emergency Care Services are provided both in and out of the Service Area. If an emergency situation should occur, you should take immediate action and seek prompt medical care. You should call 911, or the emergency number listed in the local telephone directory or go to the nearest Hospital emergency department.

4.5.1 Emergency Care

A medical emergency is a sudden unexpected illness or injury that you believe would place your life in danger or cause serious damage to your health if you do not seek immediate medical treatment. Medical emergencies include, but are not limited to:

- Heart attack
- Stroke
- Poisoning
- Loss of consciousness
- Medically necessary detoxification
- Acute abdominal pain
- Severe chest pain
- Serious burn
- Bleeding that does not stop
- Unexpected premature childbirth

Coverage is provided without Prior Authorization for Emergency Medical Screening Exams and stabilization of an Emergency Medical Condition. Hospitalization for an Emergency Medical Condition requires notification to Providence Health Plan within 48 hours, or as soon as reasonably possible following the onset of treatment, in order for coverage to continue.

Definitions:

"Emergency Medical Condition" is a medical condition that manifests itself by acute symptoms of sufficient severity that a prudent layperson, possessing an average knowledge of health and medicine, would reasonably expect that failure to receive immediate medical

attention would:

- Result in serious impairment to bodily functions;
- Result in serious dysfunction of any bodily organ or part; or
- 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.

"Emergency Services" means, with respect to an Emergency Medical Condition:

- An Emergency Medical Screening Exam that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
- Such further medical examination and treatment as are required under the Emergency Medical Treatment and Active Labor Act (42 U.S.C. 1395dd) to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at the Hospital.

"Emergency Medical Screening Exams" include medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.

Your Plan covers Emergency Services in the emergency room of any Hospital. **Emergency room Services are covered when your medical condition meets the guidelines for emergency care as stated above. Coverage includes Services to stabilize an Emergency Medical Condition and Emergency Medical Screening Exams.**

If you or a Family Member believes that immediate assistance is needed for an Emergency Medical Condition**, call 911 or go to the nearest emergency room.** Tell the emergency personnel the name of your Primary Care Provider and show them your Member ID Card.

Call your Primary Care Provider any time, any day of the week. Your Primary Care Provider or the provider-on-call will tell you what to do and where to go for the most appropriate care.

Please be prepared to pay your Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are responsible for the Copayment/Coinsurance for each Hospital emergency room visit. If you are admitted to the Hospital from the emergency room, your emergency Services Copayment/Coinsurance does not apply and all Services are subject to the Inpatient Services benefit shown in your Benefit Summary.

When you are admitted to an Out-of-Network Hospital from the emergency room, your Inpatient Services are covered under your In-Network benefit until your condition becomes stable. Once your condition is stabilized, Providence Health Plan will work with you to arrange transfer to an In-Network facility. This process is called "repatriation."

If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will not be covered.

Costs for non-emergency medical transport to facilitate repatriation to an In-Network facility

are covered in full.

The Plan does not pay for emergency room treatment for medical conditions that are not medical emergencies. Do not go to the emergency room for care that should take place in your provider's office. Routine care for sore throats, common colds, follow-up care, and prescription drug requests are not considered to be emergencies.

4.5.2 Emergency Medical Transportation

Benefits include Services for emergency medical transportation by state certified ambulance and certified air ambulance transportation. Ambulance Services are provided for transportation to the nearest facility capable of providing the necessary emergency care or to a facility specified by Providence Health Plan. Air ambulance transportation is only covered for a life-threatening medical emergency, or when ground ambulance is either not available or would cause an unreasonable risk of harm because of increased travel time. Ambulance transportation solely for personal comfort or convenience is not covered.

4.5.3 Emergency Eye Care Services

Covered Services include the initial care for Emergency Medical Conditions 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.

4.5.4 Emergency Detoxification Services

Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a Substance Abuse treatment program, as stated in section 4.10.3, 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. Continuing or follow-up care is not a Covered Service unless Prior Authorized by Providence Health Plan.

4.5.5 Urgent Care

Urgent Care is treatment you need right away for an illness or injury that is not life threatening. This includes, but is not limited to, minor sprains, minor cuts and burns, and ear, nose, and throat infections. Routine care that can be delayed until you can be seen by a physician or provider in their 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. They may either suggest that you come to the office or go to an emergency room or Urgent Care center. If you can be treated in your provider's office or at an In-Network Urgent Care center your out-of-pocket expense will usually be lower.

Please be prepared to pay the Copayment/Coinsurance, as shown in your Benefit Summary, at the time you receive care. You are also responsible for the applicable Copayment/Coinsurance shown in the Benefit Summary for any ancillary Services received, such as lab tests and X-rays, billed by the Qualified Provider.

If you are admitted to an Out-of-Network Hospital, you, or a relative, should call Providence Health Plan within 48 hours or as soon as reasonably possible.

When you are admitted to an Out-of-Network Hospital from an Urgent Care facility, your Inpatient Services are covered under your In-Network benefit until your condition becomes stable. Once your condition is stabilized, Providence Health Plan will work with you to arrange transfer to an In-Network facility. This process is called "repatriation."

If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will not be covered.

Costs for non-emergency medical transport to facilitate repatriation to an In-Network facility are covered in full.

Not all Out-of-Network facilities will file a claim on a Member's behalf. If you receive urgent care Services from an Out-of-Network facility, you must submit a claim if the facility or provider does not submit it for you. See section 6.1.1.

4.6 INPATIENT HOSPITAL AND SKILLED NURSING FACILITY SERVICES

Coverage is provided as shown in your Benefit Summary for Hospital and Skilled Nursing Facility Services.
Covered Services do NOT include care received that consists primarily of:

- Room and board and supervisory or custodial Services.
- Personal hygiene and other forms of self-care.
- Non-skilled care for senile deterioration, mental deficiency, or developmental disability.

In all cases, the following are specifically excluded from the Hospital and Skilled Nursing Facility benefit:

- Private duty nursing or a private room unless prescribed as Medically Necessary or otherwise Prior Authorized.
- Take-home medications, supplies and equipment.
- Personal items such as telephone, radio, television and guest meals.

4.6.1 Inpatient Hospital Services

Benefits are provided as shown in your Benefit Summary.

When your In-Network Provider and Providence Health Plan determine you need hospitalization, arrangements will be made for you to be admitted to a Network Hospital.

For Enrolled Out-of-Area Dependents: 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; and
- Hospital services and supplies necessary for treatment and furnished by the Hospital, such as use of the operating and recovery rooms, anesthesia, dressings, medications, whole blood and blood products, oxygen, X-ray, and laboratory Services during the period of inpatient hospitalization. (Personal items such as guest meals, slippers, etc., are not covered.)

Providence Health Plan employs professional clinical staff who may review services you receive in the Hospital. They may review your care to determine Medical Necessity, to make sure that you had quality care, and to ensure that you will have proper follow-up care.

Your provider will determine your medically appropriate length of stay. If you choose to stay in the Hospital longer than your physician advises, you will be responsible for the cost of additional days in the Hospital.

4.6.2 Skilled Nursing Facility

Benefits are provided as shown in the Benefit Summary for Covered Services from a Skilled Nursing Facility. Services must be Prior Authorized by Providence Health Plan and prescribed by your Qualified Practitioner in order to limit Hospital Confinement by providing convalescent skilled medical and nursing Services which cannot be adequately provided through a home health program. Benefits are subject to the durational limits stated in your Benefit Summary.

4.6.3 Inpatient Rehabilitative Care

Benefits are provided for physical, occupational and speech therapy Covered Services as shown in the Benefit Summary for inpatient rehabilitative care to restore or improve lost function following illness or injury. If a Member is hospitalized when rehabilitative Services begin, rehabilitation benefits will begin on the day treatment becomes primarily rehabilitative. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member's condition. Benefits are subject to the durational limits stated in the Benefit Summary. Limits do not apply to Mental Health Covered Services. (See section 4.7.2 for coverage of Outpatient Rehabilitative Services.)

4.6.4 Inpatient Habilitative Care

Coverage is provided 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 4.7.3 for coverage of Outpatient Habilitative Services.)

4.6.5 Observation Care

Benefits are provided, as shown in the Benefit Summary, for Covered Services provided by the Hospital or the Qualified Practitioner while you are held in the Hospital for observation. Observation care includes the use of a bed and periodic monitoring which are reasonable and necessary to evaluate your condition as an outpatient or determine the need for possible admission to the hospital as an inpatient. In general, the duration of observation care does not exceed 24 - 48 hours. Observation care for greater than 48 hours without inpatient admission is generally considered not Medically Necessary and may be subject to medical review.

4.7 OUTPATIENT SERVICES

4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy, and Multidisciplinary Pain Management Programs

Benefits are provided as shown in the Benefit Summary and include Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, 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. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. The Plan may require that you obtain a second opinion for some 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 3.7.

Covered Services under these benefits do not include Services for Outpatient Rehabilitative Services. See section 4.7.2 for those Services.

4.7.2 Outpatient Rehabilitative Services

Benefits are included for outpatient physical, occupational and speech therapy Covered Services provided by a physician or licensed/registered therapist, as stated in the Benefit Summary, to restore or improve lost function following illness or injury.

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. All Services are subject to review for Medical Necessity.

Covered Services under this benefit do NOT include:

- Chiropractic adjustments and manipulations of any spinal or bodily area;
- Exercise programs;
- Rolfing, polarity therapy and similar therapies; and
- Rehabilitation services provided under an authorized home health care plan as stated in section 4.11.

See section 4.6.3 for coverage of Inpatient Rehabilitative Services.

4.7.3 Outpatient Habilitative Services

Coverage is provided, as stated in the Benefit Summary, for Medically Necessary outpatient habilitative Services for maintenance, learning or improving skills and function for daily living. 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 4.6.4 for coverage of Inpatient Habilitative Services.)

4.8 MATERNITY SERVICES

Your benefits include coverage for comprehensive maternity care.

Your Benefit Summary lists your Member costs (Copayment and/or Coinsurance) per pregnancy for prenatal office visits, postnatal office visits, and delivery Provider Services. These Member costs do not apply to other Covered Services, such as lab and imaging, which you may receive for your maternity care. The specific Coinsurance or Copayment for each of these services will apply instead. Please refer to your Benefit Summary for details.

Women may choose to receive Maternity Services from a Primary Care Provider or a Women's Health Care Provider. Women's Health Care Providers include physicians specializing in obstetrics, some Primary Care Providers (if they are licensed to provide obstetrical services), physician assistants and advanced registered nurse practitioners specializing in women's health care, certified nurse midwives, and licensed direct entry midwives.

<u>Covered Services include:</u>

- Prenatal care.
- Delivery at an approved facility or birthing center.
- Postnatal care, including complications of pregnancy and delivery.
- Emergency treatment for complications of pregnancy and unexpected pre-term birth.
- Newborn nursery care*.
- Newborn nurse home visits**.

*Newborn nursery care is a facility Service covered under the Hospital Services benefit. All other Services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visit benefit.

**Newborn nurse home visits are provided for newborns up to 6 months of age, including foster and newly adopted newborns, for Oregon members residing in a community where the Oregon Health Authority (OHA) Universal Newborn Nurse Home Visiting Program is operating. Newborn nurse home visits are covered without member cost-share (unless required for the Plan to maintain HSA-qualified status) under the newborn's In-Network benefits and must be received from nurses certified by OHA to provide the services.

PLEASE NOTE: Newborn nursery care, newborn nurse home visits, and any other Services provided to your newborn are covered only when the newborn child is properly enrolled under this Plan within time frames outlined in Newborn Eligibility and Enrollment, section 8.2.4.

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.

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 with high-risk pregnancies may receive support services through care or case management. A care manager may be a social worker or a registered nurse.

Diabetes coverage during pregnancy: During pregnancy through six weeks postpartum, the Plan provides coverage in full for diabetes services, medications, and supplies when received In-Plan.

4.9 MEDICAL SUPPLIES, MEDICAL APPLIANCES, PROSTHETIC AND ORTHOTIC DEVICES AND DURABLE MEDICAL EQUIPMENT (DME)

Benefits for medical supplies, medical appliances, prosthetic and orthotic devices and Durable Medical Equipment (DME) are provided as shown in the Benefit Summary when required for the standard treatment of illness of 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.

4.9.1 Medical Supplies (including Diabetes Supplies)

Benefits are shown in the Benefit Summary for the following medical supplies and diabetes supplies:

1. Medically Necessary supplies as ordered by your Qualified Practitioner, including, but not limited to, ostomy supplies, prescribed needles, syringes and chem strips. Non-sterile examination gloves used by you or your caregiver are NOT a covered medical supply.
2. Diabetes supplies, such as needles, syringes, continuous glucose monitors and blood glucose monitors, lancets and test strips, may be purchased through Providence Health Plan In-Network medical supply providers at Participating Pharmacies. Formulary, Prior Authorization, and quantity limits may apply – please see your Formulary for details. See section 4.9.4 for coverage of diabetic equipment such as insulin pump devices.
3. Medically Necessary medical foods for supplementation or dietary replacement including non-prescription elemental enteral formula for home use, when determined to be Medically Necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition. Medical foods are also covered for the treatment of Inborn Errors of Metabolism, as described in section 4.12.2. Medical foods do not include total parenteral nutrition (TPN), which is covered under section 4.3.5.

4.9.2 Medical Appliances

Benefits are provided as shown in the Benefit Summary for the following medical appliances:

1. Casts, braces and supportive devices when used in the treatment of medical or surgical conditions in acute or convalescent stages or as immediate post-surgical care.
2. Initial and replacement contact lenses, intraocular lenses, prescription lenses or standard frame glasses, when required as a result of injury, illness or surgery, such as, but not limited to, cataract, corneal transplant surgery or for the treatment of keratoconus.
3. Rental of an oxygen unit used in the home for Members with significant hypoxemia who are unresponsive to other forms of treatment. The benefit is limited to three months from the initial date of Service unless there is clinical evidence of the need to continue.
4. Removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are subject to the benefit maximum stated in the Benefit Summary.
5. Medical devices that are surgically implanted into the body to replace or aid function (including bilateral cochlear implants). If you receive a procedure to implant a medical device, you will be responsible for any Copayment or Coinsurance for the medical device in addition to any Copayment or Coinsurance for the procedure.
6. Other Medically Necessary appliances, including Hearing Aids and Hearing Assisted Technology (HAT) as ordered by your Qualified Practitioner.

4.9.3 Prosthetic and Orthotic Devices

Benefits are provided for prosthetic and orthotic devices as shown in the Benefit Summary. Coverage is limited to those prosthetic and orthotic devices that are Medically Necessary

and included in the Medicare fee schedule for Durable Medical Equipment, Prosthetics, Orthotics and Supplies. Covered Services include rigid or semi-rigid devices used for supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck; or an artificial limb device or appliance designed to replace in whole or in part an arm or a leg; breast implants following mastectomy; artificial eyes; and maxillofacial prosthetic devices for the restoration and management of head and facial structures. (For coverage of removable custom shoe orthotics, see section 4.9.2).

4.9.4 Durable Medical Equipment (DME)

Benefits are provided for DME as shown in the Benefit Summary. Covered Services may include Medically Necessary equipment such as a hospital bed, non-motorized wheelchair, ventilator, and similar equipment as approved by 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).

4.10 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

This Plan complies with Oregon and Federal Mental Health Parity.

4.10.1 Mental Health Services

Benefits are provided for Mental Health Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions.

Covered Services include diagnostic evaluation, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services. All inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services must be Prior Authorized as specified in section 3.7.

In an emergency situation, go directly to a Hospital emergency room. You do not need Prior Authorization for emergency treatment; however, Providence Health Plan must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue.

4.10.2 Applied Behavior Analysis

Benefits are provided for Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorders, subject to the following limitations:

- Services must be Medically Necessary;
- The initial screening and an individualized treatment plan must be provided by a licensed neurologist, pediatric neurologist, developmental pediatrician, psychiatrist or psychologist, who has experience or training the diagnosis of autism spectrum disorder;
- Prior authorization is received by us;
- Benefits include coverage of any other non-excluded mental health or medical services identified in the individualize treatment plan;

- Treatment must be provided by a health care professional licensed to provide ABA Services; and
- Treatment may be provided in the Member's home or in a licensed health care facility.

Exclusions to ABA Services:

- Services provided by a family or household member;
- Services that are custodial in nature, or that constitute marital, family, or training services;
- Services that are educational or correctional that are provided by a school or halfway house or received as part of an education or training program;
- Custodial or respite care, equine assisted therapy, creative arts therapy, wilderness or adventure camps, social counseling, telemedicine, music therapy, chelation or hyperbaric chambers;
- Services provided under an individual education plan in accordance with the Individuals with Disabilities Education Act;
- Services provided through community or social programs; and
- Services provided by the Department of Human Services or the Oregon Health authority, other than employee benefit plans offered by the department and the authority.

An approved ABA treatment plan is subject to review by us, and may be modified or discontinued if review shows that the Member receiving treatment is not making measurable clinical progress toward the goals identified in the treatment plan.

4.10.3 Substance Abuse Services

Benefits are provided for Substance Abuse Services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment for other medical conditions.

Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan.

Prior Authorization is required for all inpatient, residential, day, intensive outpatient, or partial hospitalization treatment Services, as specified in section 3.7.

Treatments involving the use of methadone are a Covered Service only when such treatment is part of a medically-supervised treatment program that has been Prior Authorized.

In an emergency situation, go directly to a Hospital emergency room. You do not need Prior Authorization for emergency treatment; however, 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.

4.11 HOME HEALTH AND HOSPICE CARE

4.11.1 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.

Any visit by a person providing Services under a home health care plan, or evaluating the need for or developing a plan is considered one home health care visit. Up to four consecutive hours in a 24-hour period of home health care Service is considered one home health care visit. A home health care visit of more than four hours is considered one visit for every four hours or part thereof.

Home health care will not be reimbursed unless your Qualified Practitioner certifies that the home health care Services will be provided or coordinated by a state-licensed or Medicare-certified Home Health 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;
3. Charges for supervision of Home Health Providers; or
4. Services that consist principally of Custodial Care including, but not limited to, care for senile deterioration, mental deficiency, mental illness, developmental disability or care of a chronic or congenital condition on a long-term basis.

4.11.2 Hospice Care

Benefits are included for hospice care as shown in the Benefit Summary and as stated in this section. In addition, the following criteria must be met:

1. Your Qualified Practitioner certifies that you have a terminal illness with a life expectancy not exceeding six months; and
2. The Covered Services provided are reasonable and necessary for the condition and symptoms being treated.

When the above criteria are met, the Plan will provide benefits for a full range of Covered Services which a certified hospice care program is required to include. Covered Services include the following:

- Nursing care provided by or under the supervision of a registered nurse;

- Medical social services provided by a medical social worker who is working under the direction of a physician, including counseling for the purpose of helping you and your caregivers adjust to the approaching death;
- Services provided by your Qualified Practitioner or a physician associated with the hospice program;
- Durable Medical Equipment, medical supplies and devices, including medications used primarily for the relief of pain and control of symptoms related to the terminal illness;
- Home health aide Services for personal care, maintenance of a safe and healthy environment and general support to the goals of the plan of care;
- Rehabilitation therapies provided for purposes of symptom control or to enable you to maintain activities of daily living and basic functional skills; and
- Continuous home care during a period of crisis in which you require skilled intervention to achieve palliation or management of acute medical symptoms.

Respite care is not covered.

4.12 OTHER COVERED SERVICES

4.12.1 Genetic Testing and Counseling Services

Genetic testing and counseling are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature. Genetic testing requires Prior Authorization as shown in section 3.7.

All Direct-to-Consumer genetic tests are considered investigational and are not covered.

4.12.2 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 4.9.1.

4.12.3 Podiatry/Foot Services

Benefits include Covered Services of a podiatrist or other Qualified Practitioner and are provided as shown in the Physician/Provider Services section of the Benefit Summary. Covered Services include, but are not limited to, the fitting and follow up exam for removable custom orthotic shoe inserts when required as a result of surgery, congenital defect or diabetes. Removable custom orthotic shoe inserts are covered as stated in section 4.9.2 (Medical Appliances). Covered Services do not include routine foot care and the removal of corns or calluses, unless you have diabetes.

4.12.4 Reconstructive Surgery

Reconstructive Surgery is covered for conditions resulting from congenital defects, developmental abnormalities, trauma, infection, tumors or disease. Reconstructive surgery may be performed to correct a functional impairment in which the special, normal or proper action of any body part or organ is damaged; when necessary because of accidental injury or to correct scars or defects from accidental injury; or when necessary to correct scars or defects to the head or neck resulting from covered surgery. Benefits are covered as those Services listed in the Benefit Summary based upon the type of Services received. For Restoration of Head or Facial Structures; Limited Dental Services, see section 4.12.6.

4.12.5 Reconstructive Breast Surgery

Members who have undergone mastectomy are entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). "Mastectomy" means the surgical removal of breast tissue and breast lumps due to malignancy or suspected malignancy.

Benefits for Reconstructive Surgery of the breast are covered as those Services listed in the Benefit Summary based upon the type of Services received. Reconstructive Surgery of the breast is covered for:

- Reconstruction of the involved breast following a mastectomy;
- Surgery and construction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

If you have additional questions about your WHCRA benefits, please contact Customer Service.

4.12.6 Restoration of Head/Facial Structures; Limited Dental Services

Covered Services are limited to those Services that are Medically Necessary for the purpose of controlling or eliminating infection, controlling or eliminating pain, or restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic services to improve on the normal range of conditions. Medically Necessary Covered Services include restoration and management of head and facial structures, including teeth, dental implants and bridges, that cannot be replaced with living tissue and that are defective because of trauma, disease or birth or developmental deformities, not including overbite, crossbite, malocclusion or similar developmental irregularities of the teeth or jaw.

Benefits are covered as those Services listed in the Benefit Summary based upon the type of Services received.

Exclusions that apply to Covered Services include:

- Cosmetic Services;
- Services rendered to improve a condition that falls within the normal range of such conditions;
- Routine Orthodontia;
- Services to treat tooth decay, periodontal conditions and deficiencies in dental hygiene;
- Removal of impacted teeth;

- The making or repairing of dentures;
- Orthognathic surgery to treat developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth; and
- Services to treat temporomandibular joint syndrome, including orthognathic surgery, except as provided in 4.12.7.

Outpatient Hospitalization and Anesthesia for Limited Dental Services

Benefits for outpatient hospitalization and anesthesia for dental Services are covered as those Services listed in the Benefit Summary based upon the type of Services received and will only be provided for Members with complicating medical conditions. Examples of these conditions include, but are not limited to:

- Developmental disabilities;
- Physical disabilities; or
- A combination of medical conditions or disabilities which cannot be managed safely and efficiently in a dental office.

Dental Services are excluded.

4.12.7 Temporomandibular Joint (TMJ) Services

Benefits are provided for TMJ Services from an In-Network Provider 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 4.9.2 (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.

Covered Services for TMJ conditions do not include dental or orthodontia Services.

4.12.8 Self-Administered Chemotherapy

Self-administered chemotherapy agents, including oral medications and injectable medications, are covered under your Prescription Drug benefit when received from a Participating retail or specialty Pharmacy as shown in the Benefit Summary (See section4.14).

4.12.9 Gender Dysphoria

Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for a list of services requiring Prior Authorization.

4.12.10 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.

- Services are covered in full and must be received from Network Providers and Facilities. Oral contraceptives must be purchased at Network Pharmacies.

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 Network facilities.

4.12.11 Hearing Loss Services

Definitions:

Cochlear Implant

Cochlear Implant means a device that can be surgically implanted under the skin in the bony area behind the ear (the cochlea) to stimulate hearing.

Hearing Aid

Hearing Aid means any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments, batteries, or accessory for the instrument or device, except cords.

Covered Services:

The following hearing loss services are covered under this Plan as described below. Benefits for such services are provided at the applicable benefit level for that particular type of service, as listed in your Benefit Summary.

All Covered Services must be Medically Necessary and appropriate, and prescribed, fitted, and dispensed by a licensed audiologist, hearing aid/instrument specialist, or other Qualified Practitioner.

Cochlear implants:

Cochlear implants for one or both ears, including programming, reprogramming, replacement and repair expenses. Cochlear Implants require Prior Authorization. The devices are covered under the Surgery and applicable Facility benefit.

Hearing aids & related accessories:

Medically Necessary external hearing aids and devices, as prescribed, fitted, and

dispensed by a licensed audiologist or a hearing aid/instrument specialist. Hearing aids and devices are covered under the Medical Appliances benefit. This benefit is available for one hearing aid per ear every three Calendar Years for all Members. Hearing aid batteries are covered for one box per hearing aid per Calendar Year.

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.

Hearing Assistance Technology:

- Bone conduction sound processors, if necessary for appropriate amplification of hearing loss. This benefit is available once every three Calendar Years for all Members.
- Hearing assistive technology systems, if necessary, for appropriate amplification of hearing loss. This benefit is available once every three Calendar Years for all Members.

Limits to Hearing Loss Services

Coverage for hearing loss services are provided in accordance with state and federal law.

4.12.12 Wigs

The Plan will provide coverage for one synthetic wig every calendar year for Members who have undergone chemotherapy or radiation therapy or are experiencing pharmaceutical drug-induced Alopecia at the Medical Equipment, Supplies and Devices benefit level listed in your Benefit Summary. Wigs may be purchased from any wig supplier. Wig suppliers may require Members to pay for items and submit the paid receipt to Providence Health Plan for reimbursement. For information about submitting claims, see section 6.1.1.

4.13 HUMAN ORGAN/TISSUE TRANSPLANTS

A transplant is defined as a procedure or series of procedures by which an organ or tissue is either:

- Removed from the body of one person (the donor) and implanted in the body of another person (the recipient who is a Member); or
- Removed from and replaced in the same person's body (a self-donor who is a Member).

The term transplant does not include Services related to the transfusion of blood or blood derivatives (except hematopoietic stem cells) or replacement of a cornea. Corneal replacement is covered under the applicable provider and facility surgical benefits.

4.13.1 Covered Services

Covered Services for transplants are limited to Services that:

1. Are determined by Providence Health Plan to be Medically Necessary and medically appropriate according to national standards of care;

2. Are provided at a facility approved by us or under contract with Providence Health Plan;
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 lifetime benefit maximum for transportation, food and lodging. Food and lodging is subject to a $150 per diem. Per diem expenses apply to the $5,000 travel expenses lifetime 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.

4.13.2 Benefits for Transplant Facility Services Provided to the Organ Recipient

The Member/recipient is responsible for the Coinsurance or Copayment amounts for pre-transplant services and post-transplant services at the applicable Inpatient Hospital Services and Outpatient Facility Services benefit.

The transplant procedure and related inpatient services are billed at a Global Fee. The Global Fee can include facility, professional, organ acquisition, and inpatient day charges. It does not include pre-transplant and post-transplant services. The Member/recipient is responsible for the Deductible, Coinsurance or Copayment amounts for the Global Fee at the applicable Inpatient Hospital Service benefit.

The Global Fee and the pre-transplant and post-transplant Services will apply to the Member's Out-of-Pocket Maximum.

4.13.3 Benefits for Outpatient Medications

Outpatient prescription medications for transplant-related Services, including anti-rejection (immunosuppressive) drugs, are not eligible for reimbursement under the medical benefits of this Plan. Benefits for outpatient prescription drugs are provided under this Plan's Prescription Drug Benefit and those benefits are subject to the terms and limitations of that Benefit.

4.13.4 Benefits for Physician/Provider Services Provided to the Organ Recipient

Benefits for physician/provider Services are provided as shown in the Benefit Summary. The Member/recipient is responsible for the, Coinsurance or Copayment amounts for those Services, as shown in the Benefit Summary, unless those Services are billed as a global fee with the facility Services, and those amounts will apply to the Member's Out-of-Pocket Maximum.

4.13.5 Transplant Prior Authorization

(See also section 3.5.)
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.

4.13.6 Transplant Exclusions

In addition to the exclusions listed in section 5, the following exclusions apply to human organ/tissue transplants:

- Any transplant procedure performed at a transplant facility that has not been approved by us;
- Any transplant that is Experimental/Investigational, as determined by Providence Health Plan;
- Services or supplies for any transplant that are not specified as Covered Services in section 4.13, such as transplantation of animal organs or artificial organs;
- Services related to organ/tissue donation by a Member if the recipient is not a Member or the Member/recipient is not eligible for transplant benefits under this Plan; and
- Transplant-related travel expenses for the donor and the donor's and recipient's family members.

4.14 PRESCRIPTION DRUG BENEFIT

The Prescription Drug Benefit provides coverage for prescription drugs which are Medically Necessary for the treatment of a covered illness or injury and which are dispensed by a Participating Pharmacy pursuant to a prescription ordered by a Qualified Practitioner for use on an outpatient basis, subject to your Plan's benefits, limitations and exclusions.

Prescription Drug Definition

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.

4.14.1 Using Your Prescription Drug Benefit

Your Prescription Drug Benefit requires that you fill your prescriptions at a Participating Pharmacy.

You have access to Providence Health Plan's nationwide broad pharmacy network as published in our pharmacy directory.

Providence Health Plan Participating Pharmacies are those pharmacies that maintain all applicable certifications and licenses necessary under state and federal law of the United States and have a contractual agreement with us to provide Prescription Drug Benefits.

Participating Pharmacies are designated as retail, preferred retail, specialty and mail-order Pharmacies. To view a list of Participating Pharmacies, visit our website at www.ProvidenceHealthPlan.com. You also may contact Customer Service at the telephone number listed on your Member ID Card.

- Please present your Member ID Card to the Participating Pharmacy at the time you request Services. If you have misplaced or do not have your Member ID Card with you, please ask your pharmacist to call us.
- All covered Services are subject to the Copayments or Coinsurance listed in your Benefit Summary.
- If you choose a brand-name drug when a generic-equivalent is available, any difference in cost for Prescription Drug Covered Services will not apply to your Out-of-Pocket Maximums.
- The amount paid by a manufacturer discount and/or copay assistance programs for a brand-name drug when a generic equivalent is available may not apply towards 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 Benefit or need assistance processing your prescription.

- Copayments or Coinsurance are due at the time of purchase. If the cost of your Prescription Drug is less than your Copayment, you will only be charged the cost of the Prescription Drug.
- You may be assessed multiple Copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- You may purchase up to a 90-day supply of each maintenance 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 www.ProvidenceHealthPlan.com. (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 your Medical Supplies benefits, limitations and Copayments and/or Coinsurances. See section 4.9.1 and your Benefit Summary. Diabetes supplies do not include insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.9.4.
- Self-administered chemotherapy drugs are covered under section 4.12.8 unless the benefits under this Prescription Drug Benefit allow for a lower out-of-pocket cost to you.
- Injectable medications received in your Provider's office are covered under section 4.3.5.
- Infusions, including infused medications, received at Outpatient Facilities are covered under section 4.7.1.
- Some prescription drugs require Prior Authorization or an exception to the Formulary in order to be covered. These may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in the Providence Health Plan Prescription Drug Formulary available on our website at www.ProvidenceHealthPlan.com or by contacting Customer Service.

4.14.2 Use of Out-of-Network Pharmacies

On rare occasions, such as urgent or emergency situations, you may need to use an Out-of-Network Pharmacy. If this happens, you will need to pay full price for your prescription at the time of purchase.

To request reimbursement, you will need to fill out and submit to Providence Health Plan a Prescription Drug Reimbursement form. This form is available on our website or by contacting Customer Service. When you submit the completed Prescription Drug Reimbursement form, include any itemized pharmacy receipts, along with an explanation as to why you used an Out-of-Network Pharmacy. Submission of a claim does not guarantee payment.

If your claim is approved, the Plan will reimburse you the cost of your prescription up to our Participating Pharmacy contracted rates, less your Copayment or Coinsurance if applicable. 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.

4.14.3 Prescription Drug Formulary

The Formulary is a list of Food and Drug Administration (FDA)-approved prescription drugs. It is designed to offer drug treatment choices for covered medical conditions. Formulary status is given to drugs which meet evidence-based assessment of therapeutic effectiveness, safety, pharmacoeconomic value and offer an important advantage to existing Formulary alternatives. The Formulary can help you and your Qualified Practitioner choose effective medications that are less costly and minimize your out-of-pocket expense. There are effective generic drug choices to treat most medical conditions.

Not all FDA-approved drugs are covered by Providence Health Plan. Non-formulary drug requests require a formulary exception, must be FDA-approved, Medically Necessary, and require by law a prescription to dispense. See Section 6.1 under Claims Involving Prior Authorization and Formulary Exception.

Newly approved FDA drugs will be reviewed by the Oregon Region Pharmacy and Therapeutics Committee for safety and Medical Necessity within 12 months after the drug becomes available on the market. In the case of an urgent situation, Providence Health Plan will authorize the use of a newly approved FDA drug during our review period so a Member does not go without Medically Necessary treatment.

To access the Formulary for your Plan, visit https://healthplans.providence.org/members/pharmacy-resources/.

4.14.4 Generic and Brand-Name Prescription Drugs

Both generic and brand-name drugs are covered benefits subject to the terms of your Benefit Summary. In general, generic drugs are subject to lower Copayments or Coinsurances than brand-name drugs. Please refer to your Benefit Summary for your Copayment or Coinsurance information.

If you request a brand-name drug, regardless of the reason or Medical Necessity, you will be responsible for the difference in cost between the brand-name and generic drug, in addition to the brand-name drug Copayment or Coinsurance indicated on the Benefit Summary. Your total cost, however, will never exceed the actual cost of the drug. The difference in cost between the brand-name and generic drug will not be applied toward your Out-of-Pocket Maximum, and you will continue to be responsible for the difference in cost after your Out-of-Pocket Maximum is met.

4.14.5 Prescription Drug Quantity

Prescription dispensing limits, including refills, are as follows:

1. Topicals, up to 60 grams;
2. Liquids, up to eight ounces;
3. Tablets or capsules, up to 100 dosage units;
4. Multi-use or unit-of-use, up to one container or package; as prescribed, not to exceed

a 30-consecutive-day supply, whichever is less;
5. FDA-approved women's prescription contraceptives: up to 3-months initial dispensing, then up to 12-months subsequent dispensing at any 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 our Oregon Region Pharmacy and Therapeutics Committee. Prior Authorization is required for amounts exceeding any applicable medication dispensing limits.

4.14.6 Participating Mail-Order and Preferred Retail Pharmacies

Up to a 90-day supply of prescribed maintenance drugs (drugs are those you have been on for at least 30 days and that you anticipate continuing on in the future) purchased from a Participating mail-order or preferred retail Pharmacy will be covered subject to the following specific provisions:

1. Qualified drugs under this program will be determined by us. Not all prescription drugs are available through mail-order pharmacy.
2. Not all maintenance prescription drugs are available in 90-day allotments.
3. Copayment(s) will be applied to the quantity stated on your Benefit Summary. (Some quantity limitations and Copayments for unit of use packaging may apply).

When using a mail-order pharmacy, payment is required prior to processing your order. If Providence Health Plan removes a pharmacy from its network, we will notify you of this change at least 30 days in advance. Notification may be done via the online directory or letter depending on the circumstance.

4.14.7 Prescription Drug Limitations

Prescription drug limitations are as follows:

1. All drugs must be Food and Drug Administration (FDA) approved, Medically Necessary and require by law a prescription to dispense. Not all FDA-approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety and Medical Necessity within 12 months after the drug becomes available on the market for Formulary consideration.
2. Certain drugs require Prior Authorization for Medical Necessity, place of therapy, length of therapy, step therapy, number of doses or dispensing limits. Step therapy uses our pharmacy claims history to confirm if certain drugs have been tried first by a Member. If a drug has not been tried first, cannot be tried first, or if the drug history is not available, Prior Authorization is required. For some drugs, Providence Health Plan limit the amount of the drug the Plan will cover. You or your Qualified Practitioner can contact Providence Health Plan directly to request Prior Authorization. If you have questions regarding a specific drug, please call Customer Service.
3. Specialty drugs are injectable, infused, oral, topical, or inhaled therapies that often require specialized delivery, handling, monitoring and administration and are generally high cost. These drugs must be purchased through a Providence Health Plan designated specialty pharmacy. Due to the nature of these medications, specialty drugs are limited to a 30-day supply. Specialty drugs are listed in the

Formulary. In rare circumstances specialty medications may be filled for greater than a 30-day supply; in these cases, additional specialty cost share(s) may apply.

4. Self-injectable medications are only covered when they are being self-administered and labeled by the FDA for self-administration; in some cases, a Prior Authorization may be required for the drug. Documentation of self-administration may also be required. Drugs labeled for self-administration that are being administered by a provider will fall to the Member's medical benefit.
5. Medications, drugs or hormones prescribed to stimulate growth are not covered, except when there is a laboratory-confirmed diagnosis of growth hormone deficiency for children through 18 years of age and when prescribed for the treatment of documented pituitary destruction in adults.
6. 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.
7. Vacation supply medication refill overrides are limited to a 30-day supply once per Calendar Year, unless otherwise provided under your Plan. Additional exceptions may be granted on a case-by-case basis.
8. A 30 day supply medication refill override will be granted if you are out of medication and have not yet received your drugs from a participating mail order pharmacy.

4.14.8 Prescription Drug 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, other provider or another trained person (see section 4.3.5);
2. Amphetamines and amphetamine derivatives except when used in the treatment of narcolepsy or attention deficit and/or hyperactivity disorder in children and adults;
3. Drugs prescribed that do not relate to the prevention or treatment of a covered illness or injury;
4. Drugs used for the treatment of fertility/infertility;
5. Fluoride, for Members over 10 years of age;
6. Drugs that are not provided in accordance with our formulary management program or are not provided according to our medical policy;
7. Drugs used in the treatment of fungal nail conditions;
8. Drugs prescribed by naturopathic physicians (N.D.);
9. 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;
10. Prescription drugs, including prescription combination drugs, that contain OTC products or are available in an OTC therapeutically similar form;
11. 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;
12. Drugs, which may include prescription combination drugs, placed on a prescription-only status as required by state or local law;
13. Replacement of lost or stolen medication;
14. Drugs or medicines used to treat sexual dysfunction (this exclusion does not apply to Mental Health Covered Services);

15. Drugs used in the treatment of drug-induced fatigue, general fatigue and idiopathic hypersomnia;
16. Drugs dispensed or compounded by a pharmacist that do not have at least one FDA-approved medication in therapeutic amount;
17. 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);
18. Prenatal vitamins that contain docosahexaenoic acid (DHA);
19. Drugs used for weight loss or for cosmetic purposes;
20. Drugs that are not FDA-approved or are designated as "less than effective" by the FDA (also known as "DESI" drugs);
21. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC; and
22. 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.

4.14.9 Prescription Drug Disclaimer

Providence Health Plan is not liable for any claim, injury, demand, or judgment based on tort or other grounds (including, but not limited to, warranty or merchantability) arising out of or in any connection with the sale, compounding, dispensing, manufacturing, or use of any prescription drug covered under this Plan.

4.15 CHIROPRACTIC CARE BENEFIT

The Chiropractic Care Supplemental Benefit provides coverage for Services received from Chiropractic Care Providers provided that the Services are Medically Necessary and are within the scope of practice of the provider involved in your care.

All Chiropractic Care benefits are subject to any conditions and benefit limits stated in your Chiropractic Care Benefit Summary and in this section.

All chiropractors must be licensed in the state in which they practice and must practice within the scope of their license.

4.15.1 Chiropractic Care Providers

All Members must receive Covered Services from our nationwide network of Network chiropractors. To find a chiropractic care In-Network Provider in your area, visit our website at ProvidenceHealthPlan.com/findaprovider or call Customer Service.

You do not need a physician's referral to see a chiropractor.

In rare circumstances, our national network may not include a Network chiropractor in your area. If this happens, please contact Customer Service before making an appointment. If Customer Service is unable to locate an In-Network Provider within a reasonable distance, authorization for use of an Out-of-Network Provider will be provided.

In some cases, you will need to pay the Out-of-Network Provider directly for the care you receive, and then submit your itemized billing statement to:

Providence Health Plan
Attn: Claims Dept.
P.O. Box 3125
Portland, OR 97208-3125

Reimbursement for services from Out-of-Network Providers is subject to Plan approval. The Plan will reimburse you the cost of your services at a Usual, Customary and Reasonable rate, less your applicable Copayment or Coinsurance. You will be responsible for all amounts over the UCR.

4.15.2 Chiropractic Care Services

Covered Services from chiropractors:

- Office visits.
- Chiropractic manipulation of the spine, joints and/or musculoskeletal soft tissue, a re-evaluation, and/or other Services in various combinations.
- Adjunctive physiotherapy which may include ultrasound, hot packs, cold packs, electrical muscle stimulation or other therapies and procedures which are Medically Necessary for the treatment of neuromusculoskeletal disorders.
- Related diagnostic X-rays and laboratory Services.

The following services are NOT covered from chiropractors:

- Preventive care services.
- Services, exams and/or treatments for conditions other than neuromusculoskeletal disorders.
- All chiropractic appliances or Durable Medical Equipment.
- Adjunctive physiotherapy not associated with chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissues.
- Clinical laboratory studies performed in a chiropractor's office.
- Venipuncture.
- Services received from a chiropractor that are not listed as a Covered Service.
- Hypnotherapy, behavior training, sleep therapy and weight programs.
- Education programs, self-care or self-help programs or any self-help physical exercise training or any related diagnostic testing.
- Transportation costs including local ambulance charges.
- Massage therapy.
- Thermography.
- Therapeutic modalities and procedures that are considered by us or our authorizing agent to be invasive.
- Emergency care and Urgent/Immediate care services.
- Any service or supply that is not permitted by state law with respect to the chiropractor's scope of practice.
- Services in excess of the benefit limits listed in the Chiropractic Care Supplemental Benefit Summary.
- Services received from Out-of-Network Providers, except as discussed in this section.

5. EXCLUSIONS

In addition to those Services listed as not covered in section 4, 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;
- Are not a Covered Service or relate to complications resulting from a Non-Covered Service, except for Services provided as Emergency Care as described in section 4.5;
- Are not furnished by a Qualified Practitioner or Qualified Treatment Facility;
- Are provided by or payable under any health plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law;
- Are provided while you are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies, except to the extent provided by 38 U.S.C. § 1729 as it relates to non-military Services provided at a Veterans Administration Hospital or facility;
- Are provided while you are in the custody of any law enforcement authorities or while incarcerated, except as provided in section 3.3;
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos, books and educational programs to which drivers are referred by the judicial system, and volunteer mutual support groups;
- Are provided to yield primarily educational outcomes, except as otherwise covered under the Preventive Services benefit described in section 4.1. An outcome is "primarily educational" if the outcome's fundamental, first, or principal character is to provide you with enduring knowledge, skill, or competence through a process of repetitive positive reinforcement over an extended length of time. An outcome is "enduring" if long-lasting or permanent;
- Are performed in association with a Service that is not covered under this Plan, except Emergency Services;
- Are provided for any injury or illness that is sustained by any Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the Member. This exclusion also applies to injuries and illnesses that are the subject of a claim settlement 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. This exclusion also applies to charges applied to the deductible of such contract or insurance. Any benefits or Services provided under this Plan that are subject to this exclusion are provided solely to assist you and such assistance does not waive our right to reimbursement or subrogation as specified in section 6.3. This exclusion also applies to Services and supplies after you have received proceeds from a settlement as specified in section 6.3.3;
- Are provided in an institution that specializes in treatment of developmental disabilities, except as provided in section 4.10.2;
- Are provided for treatment or testing required by a third party or court of law which is not Medically Necessary;
- Are Experimental/Investigational;
- Are determined by us not to be Medically Necessary for diagnosis and treatment of an injury or illness;
- Are received by a Member under the Oregon Death with Dignity Act;
- Have not been Prior Authorized as required by this Plan; and
- Relate to any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member, if such Member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony or misdemeanor punishable by up to a year's imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or mental health condition).

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 4.13;
- Services for Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment (DME), except as described in section 4.9;
- Charges for Services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to, air conditioners, air purifiers, vacuum cleaners, motorized transportation equipment, escalators, elevators, tanning beds, ramps, waterbeds, hypoallergenic mattresses, cervical pillows, swimming pools, whirlpools, spas, exercise equipment, gravity lumbar reduction chairs, home blood pressure kits, personal computers and related equipment or other similar items or equipment;
- Physical therapy and rehabilitative Services, except as provided in sections 4.6.3 and 4.7.2;

- "Telephone visits" by a physician or "environment intervention" or "consultation" by telephone for which a charge is made to the patient, except as covered in section 4.3.2.
- "Get acquainted" visits without physical assessment or diagnostic or therapeutic intervention provided and online treatment sessions;
- Missed appointments;
- Non-emergency medical transportation;
- Allergy shots and allergy serums, except as provided in section 4.3.5;
- All Services and supplies related to the treatment of obesity or morbid obesity, except as provided in section 4.1.6;
- Services for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas, except as provided in section 4.1.6;
- Transportation or travel time, food, lodging accommodations and communication expenses except as provided in sections 3.8 and 4.13 and with our prior approval;
- Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
- Massage therapy;
- Light therapy for seasonal affective disorder, including equipment;
- Any vitamins, dietary supplements, and other non-prescription supplements, except as required by federal or Oregon state law;
- Services for genetic testing are excluded, except as provided in section 4.12.1. Genetic testing is not covered for screening, to diagnose carrier states, or for informational purposes in the absence of disease;
- Services to modify the use of tobacco and nicotine, except as provided in section 4.1.8 or when provided as Extra Values or Discounts (see our website at www.ProvidenceHealthPlan.com), where available;
- Cosmetic Services including supplies and drugs, except as approved by us and described in section 4;
- Services, including routine physical examination, immunizations and vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs, college entrance or for the purpose of traveling or obtaining a passport for foreign travel;
- Non-sterile examination gloves;
- Sales taxes, handling fees and similar surcharges, as explained in the definition of UCR;
- Air ambulance transportation for non-emergency situations is not covered, except as provided in section 4.5.2;
- Treatments that do not meet the national standards for Mental Health and Substance Abuse professional practice;
- Services provided under a court order or as a condition of parole or probation or instead of incarceration which are not Medically Necessary;
- Personal growth services such as assertiveness training or consciousness raising;
- School counseling and support services, peer support services, tutor and mentor services; independent living services, household management training, and wraparound services that are provided by a school or halfway house and received as part of an educational or training program;

- Recreation services, therapeutic foster care, and wraparound services; emergency aid for household items and expenses; services to improve economic stability, and interpretation services;
- Evaluation or treatment for education, professional training, employment investigations, and fitness for duty evaluations;
- Community Care Facilities that provide 24-hour non-medical residential care;
- Speech therapy, physical therapy and occupational therapy services provided in connection with treatment of psychosocial speech delay, learning disorders, including mental retardation and motor skill disorders, and educational speech delay including delayed language development (except as provided in sections 4.6.3 and 4.7.2);
- Counseling related to family, marriage, sex and career including, but not limited to, counseling for adoption, custody, family planning or pregnancy, in the absence of a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis;
- Neurological Services and tests including, but not limited to, EEGs, PET, CT, MRA and MRI imaging Services, and beam scans (except as provided in section 4.4.1);
- Vocational, pastoral or spiritual counseling;
- 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 licensed acupuncturists, a physician performing acupuncture Services, naturopathic physicians, chiropractic physicians and licensed massage therapists, except as provided in section 14.15;
- Services of homeopaths; faith healers; or lay, unlicensed direct entry, and certified professional midwives; and
- Services of any unlicensed providers.

Exclusions that apply to Reproductive Services:

- All services related to sexual disorders or dysfunctions regardless of gender or cause (this exclusion does not apply to Mental Health Covered Services);
- All of the following services:
    - All services related to surrogate parenting, except Maternity Services as described in section 4.8;
    - All services related to in vitro fertilization, including charges for egg/semen harvesting and storage;
    - All services related to artificial insemination, including charges for semen harvesting and storage;
    - Diagnostic testing and associated office visits to determine the cause of infertility;
    - All of the following services when provided for the sole purpose of diagnosing and treating an infertile state or artificial reproduction:
        - Physical examination;
        - Related laboratory testing;
        - Instruction;

        - Medical and surgical procedures, such as hysterosalpingogram, laparoscopy, or pelvic ultrasound; and
        - Related supplies and prescriptions.

    For the purpose of this exclusion:
    - Infertility or infertile means the failure to become pregnant after a year of unprotected intercourse or the failure to carry a pregnancy to term as evidenced by three consecutive spontaneous abortions.
    - Artificial reproduction means the creation of new life other than by the natural means.
- Termination of pregnancy, unless there is a severe threat to the mother, or if the life of the fetus cannot be sustained;
- Reversal of voluntary sterilization;
- Male condoms and other over-the-counter birth control products for men; 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; and
- Orthoptics and vision training; and
- Services for routine eye care and vision care, vision exams/screenings, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in sections 4.1.1, 4.1.5, 4.5.3 and 4.9.2.

Exclusions that apply to Hearing Services:

- Replacement of lost or broken hearing aids are generally not covered, except for one time if a loss or damage claim is made within the first year of purchase;
- Repair of hearing aids outside of the warranty period are not covered. Repair needs during the warranty period should be discussed with your provider;
- Hearing aids prescribed and ordered prior to coverage, or prescribed or ordered after termination of coverage, whichever occurs first; and
- Hearing aids, hearing therapies and/or devices, except as provided in section 4.12.11.

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 us and described in sections 4.12.6;
- Services for orthognathic surgery, except as approved by us and described in section 4.12.6;
- Services to treat temporomandibular joint syndrome (TMJ), except as provided in section 4.12.7; and
- Dentures and orthodontia, except as provided in sections 4.12.6.

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 4.9.2.

Exclusions that apply to Prescription Drugs, Medicines and Devices:

- In addition to the exclusions listed in section 4.14.8; 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.

6. 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.

6.1 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 is not a bill. An EOB explains how Providence Health Plan processed your claim, and will assist you in paying the appropriate Member responsibility to your provider. Copayment or Coinsurance services or amounts not covered and general information about our processing of your claim are explained on an EOB.

Time Frames for Processing Claims

If 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 if 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, you will be sent a separate request for the information and you will have 45 days to submit the additional information. Once the additional information from you 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 additional information is needed to process the request, Providence Health Plan will provide written notice to the Member and the provider within two business days of receiving the Prior Authorization request. The Member and the provider will have 15 days to submit the additional information. Within two business days of receipt of the additional information, Providence Health Plan will complete their review and provide written notice of its decision to the Member and the provider of their decision. 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 24 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.

6.1.1 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 (i.e., a Coordinated Care Organization) will be made in accordance with ORS 743B.470, which establishes payment requirements for claims submitted by the Oregon state Medicaid agency.

Payment of all claims will be made within the time limits required by OAR 836-080-0235, the Oregon insurance Division's administrative rule setting standards for prompt payment. Please send all claims to:

Providence Health Plan
Attn: Claims Dept.
P.O. Box 3125
Portland, OR 97208-3125

6.1.2 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.

6.2 COORDINATION OF BENEFITS

This Coordination of Benefits (COB) section applies when a Member has health care coverage under more than one Plan. The term "Plan" is defined below for the purposes of this COB section. The order of benefit determination rules 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.

6.2.1 Definitions Relating to Coordination of Benefits

Plan

Plan means any of the following that provides benefits or Services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: group and individual health insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law and group and individual insurance contracts and Subscriber contracts that pay or reimburse for the cost of dental care.
2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare Supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage listed under (1) or (2) above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan

This Plan means, as used in this COB section, the part of this contract providing health care benefits to which this COB section applies and which may be reduced because of the benefits of other plans. Any other part of this contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB

provision to coordinate other benefits.

The order of benefit determination rules listed in section 6.2.2 determine whether This Plan is a Primary plan or Secondary plan when a Member has health care coverage under more than one Plan.

When This Plan is primary, Providence Health Plan determines payment for benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, Providence Health Plan determines benefits after those of another Plan and may reduce the benefits payable so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense

Allowable expense means a health care expense, 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.

6.2.2 Order of Benefit Determination Rules

When a Member is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan.
    1. Except as provided in Paragraph (2) below, a Plan that does not contain a COB provision that is consistent with the State of Oregon's COB regulations is always primary unless the provisions of both Plans state that the complying Plan is primary.
    2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

B. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

C. Each Plan determines its order of benefits using the first of the following rules that apply:
    1. Non-Dependent or Dependent. The Plan that covers a Member other than as a Dependent, for example, as an employee, Subscriber or retiree is the Primary plan and the Plan that covers the Member as a Dependent is the Secondary plan. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Member as a Dependent; and primary to the Plan covering the Member as other than a Dependent (e.g., a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Member as an employee, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
    2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Member is a Dependent child covered by more than one Plan the order of benefits is determined as follows:
        a) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
            i. The Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary plan; or

ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

b) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   i. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
   ii. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
   iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
   iv. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the Dependent child are as follows:
      - The Plan covering the Custodial parent, first;
      - The Plan covering the spouse of the Custodial parent, second;
      - The Plan covering the non-custodial parent, third; and then
      - The Plan covering the Dependent spouse of the non-custodial parent, last.

c) For a Dependent child covered under more than one Plan of individuals who are not the parents of the Dependent child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the Dependent child.

d) For a Dependent child:
   i. Who has coverage under either or both parents' plans and also has coverage as a Dependent under a spouse's plan, the rule in paragraph (5) applies.
   ii. In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Subparagraph (a) to the Dependent child's parent(s) and the Dependent's spouse.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a Member as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same Member as a retired or laid-off employee is the Secondary plan. The same would hold true if a Member is a Dependent of an active employee and that same Member is a

Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a Member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the Member as an employee, subscriber or retiree or covering the Member as a Dependent of an employee, Subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the Member the longer period of time is the Primary plan and the Plan that covered the Member the shorter period of time is the Secondary plan.
6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than would have paid had This Plan been the Primary plan.

6.2.3 Effect on the Benefits of This Plan

When This Plan is secondary, benefits may be reduced so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

If a Member is enrolled in two or more Closed panel plans and if, for any reason, including the provision of services by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

6.2.4 Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply this COB section and to determine benefits payable under This Plan and other Plans. Providence Health Plan may get the facts needed from, or give them to, other organizations or persons for the purpose of applying this section and determining benefits payable under This Plan and other Plans covering a Member claiming benefits. Providence Health Plan 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 Providence Health Plan needs to apply this section and determine benefits payable.

6.2.5 Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan.

This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

6.2.6 Right of Recovery

If the amount of the payments made by This Plan is more than what should have paid under this COB section, This Plan may recover the excess from one or more of the persons This Plan paid or for whom This Plan have paid; or any other person or organization that may be responsible for the benefits or services provided for the Member. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

6.2.7 Coordination with Medicare

In all cases, coordination of benefits with Medicare will conform with federal statutes and regulations. Medicare means Title XVIII of the Social Security Act, as enacted or amended. Medicare eligibility and how This Plan determines benefit limits 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.

6.3 THIRD-PARTY LIABILITY/SUBROGATION

The following provisions will apply when you or any other Member has received Services for a condition for which one or more third parties may be responsible. "Third party" means any person other than the Member (the first party to the provisions of this Plan), 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 us 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 9.4. 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 the Plan under these provisions.

6.3.1 Third-Party Liability/Subrogation and How It Affects You

Third-party liability refers to claims that are in whole or part the responsibility of someone besides the 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, the Plan 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 the Plan makes claim payments 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 the 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, the Plan is 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 has a security interest in and lien upon any recovery to the extent of the amount of benefits paid by the Plan and for the Plan's expenses in obtaining a recovery. If the Member should either decline to pursue a claim against a third party that the Plan believes is warranted or refuse to cooperate with the Plan in any third party claim that the Member does pursue, the Plan has 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, the Plan needs 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 Providence Health Plan office. A Providence Health Plan employee who specializes in third-party liability/subrogation can discuss these procedures and what you or the Member needs to do.

6.3.2 Proceeds of Settlement or Recovery

Subject to paragraph 6.3.4 below, if for any reason 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 the Plan 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 the Plan for the condition, calculated using the 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 the Plan's first priority to this repayment and assigns to us 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 the Plan. 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 the Plan directly from the settlement or recovery in the amount provided by this section.

The Member must complete the Plan's trust agreement, by which the Member and any Member's attorney (or other agent) must confirm the obligation to reimburse the Plan 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 the Plan. The agreement must remain in effect and the Plan 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 the Plan to exercise the Plan's rights under this section, it serves as a reminder to the Member and directly obligates any Member's attorney to act in accord with the Plan's rights.

6.3.3 Suspension of Benefits and Reimbursement

Subject to paragraph 6.3.4 below, after the Member has received proceeds of a settlement or recovery from the third party, the Member is responsible for payment of all medical expenses for the continuing treatment of the illness or injury that 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 the Plan as required by this section, the Plan is entitled to offset future benefits otherwise payable under this Plan, or under any future contract or plan with Clackamas County, 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 the 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 the 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 the Plan has not approved in advance. In no event shall the amount reimbursed to the Plan be less than the maximum permitted by law.

6.3.4 Special Rules for Motor Vehicle Accident Cases

If the third party recovery is payable to you or any enrolled Family Member as the result of a motor vehicle accident or by a motor vehicle liability or underinsured insurer, the rules in paragraphs 6.3.2 and 6.3.3 above are modified as provided below.

Before the Plan will be entitled to recover 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.

7. PROBLEM RESOLUTION

7.1 INFORMAL PROBLEM RESOLUTION

All employees of Providence Health Plan share responsibility for assuring Member satisfaction. If you have a problem or concern about your coverage, including benefits or Services by In-Network Providers or payment for Services by Out-of-Network Providers, please ask for Providence Health Plan's 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, Providence Health Plan will make efforts to accommodate your requirements. Please contact Customer Service for help with whatever special needs you may have.

7.2 MEMBER GRIEVANCE AND APPEAL

Definitions:

Adverse Benefit Determination

An Adverse Benefit Determination means a:

- Denial of eligibility for or termination of enrollment in this Plan;
- Rescission or cancellation of coverage under this Plan;
- Source-of injury exclusion, network exclusion, Annual benefit limit or other limitation on otherwise Covered Services;
- Determination that a health care item or service is Experimental/Investigational or not Medically Necessary; or
- Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care.

Appeal

A type of Grievance that is a written request from a Member or an Authorized Representative of the Member requesting further consideration of an Adverse Benefit Determination.

Authorized Representative

An individual who by law or by the authorization of a Member may act on behalf of the Member.

Concurrent Care

An approved ongoing course of treatment to be provided over a period of time or for a specified number of treatments.

Grievance

A communication from a Member or an Authorized Representative of a Member expressing dissatisfaction with an Adverse Benefit Determination, without specifically declining any right to Appeal or review, that is:

- In writing, for an internal Appeal or an external review; or in writing or orally, for an expedited response or an expedited external review; or
- A written complaint submitted by a Member or an Authorized Representative of a Member regarding the:
    - Availability, delivery or quality of a health care service;

- Claims payment, handling or reimbursement for health care services and, unless the Member has not submitted a request for an internal Appeal, the complaint is not disputing an Adverse Benefit Determination; or
- Matters pertaining to the contractual relationship between a Member and Providence Health Plan.

7.2.1 Your Grievance and Appeal Rights

If you disagree with Providence Health Plan's decision about your medical bills or health care services, you have the right to an 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 Providence Health Plan will consider that information in the 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. Providence Health plan 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 Providence Health Plan's decision on your Grievance or Appeal of a denied Prior Authorization or Concurrent Care request, you may request an expedited review by calling Customer Service at 503-574-7500 or 800-878-4445 outside of 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, you will be notified of the 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 reconsideration of the decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. Providence Health Plan will then notify you of the reconsideration decision within 24 hours of receiving your request.

7.2.2 Internal Grievance or Appeal

You must file your internal Grievance or Appeal within 180 days of the date on the notice of the initial Adverse Benefit Determination, or that initial determination will become final. Please advise Providence Health Plan of any additional information that you want considered in 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 for the review process. Your Grievance or Appeal will be reviewed by Providence Health Plan staff not involved in the initial determination. You may present your case in writing. Once a final determination is made you will be sent a written explanation of the decision.

7.2.3 External Review

If you are not satisfied with the internal Grievance or Appeal decision and your Appeal is of an Adverse Benefit Determination that involves (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care or (e) an exception to the Plan's prescription drug formulary, you may request an external review by an IRO. Your request must be made in writing within 180 days of receipt of the internal Grievance or Appeal decision, or that internal decision will become final. If you agree, Providence Health Plan may waive the requirement that you exhaust the internal review process before beginning the External Review process. Providence Health Plan will notify the Oregon Insurance Division within two business days of receiving your request for external review, at which point an IRO will be assigned to the case by the Oregon Insurance Division and Providence Health Plan will forward complete documentation regarding the case to the IRO.

If you request an external review you must agree to authorize release of medical records needed by the IRO and submit any additional information to the IRO no later than five days after the appointment of the IRO, or 24 hours in cases of expedited review. The IRO is entirely independent of the Plan and Providence Health Plan and performs its review under a contract with the Oregon Insurance Division. The IRO will notify you and Providence Health Plan of its decision within three days for expedited reviews and within 30 days when not expedited. **The Plan and Providence Health Plan agree to be bound by and to comply with the IRO decision when the decision involves, (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care or (e) an exception to the Plan's prescription drug formulary.**

The Plan pays all costs for the handling of external review cases and Providence Health Plan administers these provisions in accordance with the insurance laws and regulations of the State of Oregon. **If we do not comply with the IRO decision, you have the right to sue us under applicable Oregon law.**

7.2.4 How to Submit Grievances or Appeals and Request Appeal Documents

To submit your Grievance or Appeal or requests for External Review, you may contact Customer Service at 503-574-7500 or 800-878-4445. If you are hearing impaired and use a Teletype (TTY) Device, please call the TTY line at 711. Written Grievances or Appeals should be sent to:

Providence Health Plan
Appeals and Grievance Department
P.O. Box 4158
Portland, OR 97208-4158

You may fax your Grievance or Appeal 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

If your plan is governed by ERISA, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). If your plan is not governed by ERISA, you may contact the Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789.

8. 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 and your Employer must provide Providence Health Plan with evidence of eligibility as requested.

8.1 EMPLOYEE ELIGIBILITY AND ENROLLMENT

8.1.1 Employee Eligibility Date

An employee is eligible for coverage as specified in the Eligible Employee definition.

8.1.2 Employee Effective Date

Coverage begins for an Eligible Employee as specified in the Effective Date of Coverage definition.

8.1.3 Employee Enrollment

The Eligible Employee must enroll on forms (paper or electronic) provided and/or accepted by Clackamas County. To obtain coverage, an Eligible Employee must enroll within 30 days to enroll after becoming eligible. An enrolled Eligible Employee is referred to as the Subscriber.

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.

In certain situations, you and/or your Eligible Family Dependents may qualify to enroll during a special enrollment period. See section 8.3 for additional information.

8.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

8.2.1 Eligibility Date

Coverage begins for each Eligible Family Dependent on:

1. The Effective Date of Coverage for the Subscriber if the individual is an Eligible Family Dependent on that date;
2. For any Eligible Family Dependents acquired on the date of the Subscriber's marriage, on the first day of the calendar month following receipt of the enrollment request, within 60 days of the Subscriber's marriage;
3. The date of birth of the biological child of the Subscriber or Spouse;
4. The date a child is placed with the Subscriber or Spouse for the purpose of adoption by the Subscriber or Spouse;
5. The date the Subscriber or Spouse is required to provide health coverage to a child under a qualified medical child support court or administrative order; or
6. The date on which legal guardianship status begins.

8.2.2 Additional Requirements for Eligible Family Dependent Coverage

An Eligible Employee may cover Eligible Family Dependents ONLY if the Eligible Employee is also covered, and Clackamas County receives the completed enrollment form requesting Dependent coverage.

8.2.3 Eligible Family Dependent Enrollment

You must enroll Eligible Family Dependents on forms provided and/or accepted by Clackamas County. No Eligible Family Dependent will become a Member until Clackamas County approves that Eligible Family Dependent for coverage. To obtain coverage, the Eligible Family Dependent must enroll within 30 after becoming eligible as indicated in section 8.2.1 (see section 8.2.4 regarding newborn and adopted children). The next earliest time your Eligible Family Dependent may enroll is the next occurring Open Enrollment Period. In addition, an Eligible Employee and/or Eligible Family Dependent may qualify to enroll during a special enrollment period as described in section 8.3.

8.2.4 Newborn Eligibility and Enrollment

A newborn or adopted child of a Member who meets the definition of an Eligible Family Dependent is eligible for coverage from the date of birth or placement for the purpose of adoption as long as enrollment occurs within 60 days from birth or placement and additional Premium, if any, is paid to Clackamas County. 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 8.2.3 and 8.3.

8.2.5 Open Enrollment Period

Clackamas County will provide an Open Enrollment Period each Plan Year. The Effective Date of Coverage for new Members who enroll during the Open Enrollment Period is the first day of the Plan Year for which they enroll.

8.2.6 Changes in Eligibility

When an eligibility change occurs, you need to make sure Clackamas County is notified of the change. Address changes can be made by contacting Clackamas County Benefits & Wellness.

For the following changes, you, as the Subscriber, must obtain an enrollment form from Clackamas County's benefit office. You need to submit this form to your Employer for you and all your Eligible Family Dependents when:

- You marry and wish to enroll your new Spouse;
- A Dependent's limiting age occurs; or
- You or one of your Dependents has a legal name change.

If you have questions regarding eligibility changes, please contact Clackamas County Benefits & Wellness.

8.2.7 Members No Longer Eligible for Coverage

If you divorce or are legally separated, your Spouse is no longer eligible for coverage as a Dependent. You must disenroll your Spouse as a Dependent from your Plan at the time the divorce or legal separation is final. Your Spouse's children will be able to continue coverage under the Plan so long as the children continue to qualify as your Eligible Family Dependents.

You must inform Clackamas County of these changes by completing a new enrollment form. Check with Clackamas County's benefits office or contact Customer Service 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 section 10. Ask Clackamas County or call Customer Service for continuation coverage eligibility information.

8.3 SPECIAL ENROLLMENT PERIODS

If you declined enrollment for yourself as a Subscriber or for an Eligible Family Dependent (including your Spouse) during a previous enrollment period (as stated in sections 8.1 and 8.2), you may be eligible to enroll yourself or the Eligible Family Dependent during a "special enrollment period" provided that you request enrollment within 60 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
- Enroll in any benefit option offered by the Employer for which the Subscriber and Eligible Family Dependent is eligible.

8.3.1 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, the Plan 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 the Plan 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 benefits; and the individual applies for coverage under this Plan within 60 days after the claim is denied.

Effective Date: Coverage under this Plan will take effect on the first day after the other coverage ended.

8.3.2 New 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, birth, adoption or placement for adoption; the Plan 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 60 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.

Effective Date:

- in the case of marriage, on the first day of the calendar month following Clackamas County's receipt of the enrollment request, or on an earlier date as agreed to by Clackamas County; 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.

8.3.3 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 or minor child under your Health Benefit Plan, the Plan 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 60 days after the issuance of the court order.

Effective Date: The date specified in the court order.

8.3.4 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 arrangement, the Plan 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.

8.4 LEAVE OF ABSENCE AND LAYOFFS

A Subscriber on leave of absence or layoff status may continue to be covered under this Plan as though actively at work for a period of time, if any, as stated in the Eligible Employee definition. An Employee who returns to work as an Eligible Employee after coverage has lapsed must re-enroll for coverage as specified in section 8.1.3.

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), is administered in accordance with those Acts and this Summary Plan Description.

9. TERMINATION OF MEMBER COVERAGE

9.1 TERMINATION DATES

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 Clackamas County;
3. The last day of the coverage period in which a Subscriber no longer qualifies as a Subscriber, as stated in the Summary Plan Description;
4. The date a Member enters full-time military, naval or air service, except as provided under federal USERRA requirements;
5. The last day of the coverage period in which a Subscriber retires;
6. 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;
7. For a Family Member, the date the Subscriber's coverage terminates;
8. For a Family Member, the last day of the month in which the individual no longer qualifies as an Eligible Family Dependent;
9. For any benefit, the date the benefit is deleted from this Plan;
10. For a Member, the date of disenrollment from this Plan as described in section 9.4;
11. For a Member, the date any fraudulent information is provided; or
12. For a Member, the date we discover any breach of contractual duties, conditions or warranties, as determined by us.
13. For a Subscriber that is a Non-Medicare Eligible Early Retiree, the last day of the month in which the Retiree becomes eligible for Medicare.

You and the Employer are responsible for advising Clackamas County 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 Clackamas County.

See section 7, Problem Resolution, for your Grievance and Appeal rights.

9.2 TERMINATION AND RESCISSION OF COVERAGE DUE TO FRAUD OR ABUSE

Coverage under this Plan, either for you or for your covered Dependent(s), may be rescinded (meaning your coverage is retroactively canceled) or terminated in case of a fraud or intentional misrepresentation of material fact by you or by your covered Dependent in obtaining, or attempting to obtain, benefits under this Plan.

If coverage is rescinded, the Plan will retain any money you paid for coverage as liquidated damages and will have the right to recover from you or from your covered Dependents the benefits paid as a result of such wrongful activity. Providence Health Plan will provide all affected Plan participants with 30 days' notice before rescinding coverage.

9.3 NON-LIABILITY AFTER TERMINATION

Upon termination of this Plan, Clackamas County shall have no further liability beyond the effective date of the termination unless the Member continues, without lapse of membership, under another Clackamas County plan.

9.4 DISENROLLMENT FROM THIS PLAN

"Disenrollment" means that your coverage under this Plan is terminated 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 Clackamas County or Providence Health Plan employees; or
4. You have allowed a non-Member to use your Member ID Card to obtain Services.

9.5 NOTICE OF CREDITABLE COVERAGE

Providence Health Plan will provide upon request written certification of the Member's period of Creditable Coverage when:

- A Member ceases to be covered under this Plan;
- A Member on COBRA coverage ceases that coverage; and
- A Member requests a Notice of Creditable Coverage within 24 months of the termination of coverage.

9.6 CLACKAMAS COUNTY'S RIGHT TO TERMINATE OR AMEND PLAN

Clackamas County 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 Clackamas County.

10. 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 and which are generally outlined below. Please contact Clackamas County as soon as possible for details if you think you may qualify for group COBRA or state continuation coverage.

10.1 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.

10.1.1 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.

10.1.2 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.

10.1.3 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 who is properly enrolled under the terms of this Plan during the COBRA continuation period will be a qualified beneficiary.

10.1.4 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 Clackamas County 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 Clackamas County 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.

10.1.5 Type of COBRA Continuation Coverage

A qualified beneficiary will be provided the same coverage that was in effect immediately prior to the qualifying event.

10.1.6 COBRA Election Rights

A Subscriber or their Spouse or Domestic Partner may elect continuation coverage for all covered Family Members. In addition, each Family Member has an independent right to elect COBRA. Thus, a Family Member may elect continuation coverage even if the Subscriber does not.

10.1.7 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 Clackamas County 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.

10.1.8 Length of COBRA Continuation Coverage

<u>18-Month Continuation Period</u>

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 their 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 Clackamas County 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 Dependent child 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.

10.1.9 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.

10.1.10 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/.

10.1.11 When COBRA Continuation Coverage Ends

COBRA Continuation coverage will end automatically for you and your Family Members when any of the following events occurs:

- Clackamas County 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;
- 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.

11. MEMBER RIGHTS AND RESPONSIBILITIES

11.1 GENERAL MEMBER (PARTICIPANT) RIGHTS AND RESPONSIBILITIES

As a Member of Providence Health Plan, you should know what to expect from Providence Health Plan, as well as what Providence Health Plan asks from you. Nobody knows more about your health than you and your doctor. Providence Health Plan takes 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. Providence Health Plan wants you to have a positive experience, and 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, the providers, and the benefits and Services you have available to you as a Member.
- Receive information that helps you select a Qualified Practitioner whom you trust and with whom you feel comfortable.
- A candid discussion of appropriate or Medically Necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Receive information and clinical guidelines from your health care provider or your health plan that will enable you to make thoughtful decisions about your health care.
- Actively participate in decisions that relate to your health and your medical care through discussions with your health care provider or through written advance directives.
- Have access to medical Services that are appropriate for your needs.
- Express a concern or an Appeal and receive a timely response from Providence Health Plan.
- Have your claims paid accurately and promptly.
- Request a review of any service not approved, and to receive prompt information regarding the outcome.
- Be informed about and make recommendations regarding Providence Health Plan's member rights and responsibilities policy.
- Refuse care from specific providers.

Members have the responsibility to:

- Read and understand the information in and the terms of your Plan. Neither the Plan nor Providence Health Plan will have liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact Customer Service. Providence Health Plan will assist you in understanding and complying with the terms of the Plan.
- Talk openly with your physician or provider, understand your health problem and work toward a relationship built on mutual trust and cooperation.
- Develop mutually agreed upon treatment goals with your Qualified Practitioner, to the degree possible, and follow treatment plans and instructions.
- Supply to the extent possible information Providence Health Plan 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 Customer Service know if you have concerns or if you feel that any of your rights are being compromised, so that Providence Health Plan can act on your behalf.
- Call or write within 180 days of Service if you wish to request a review of Services provided or Appeal a Providence Health Plan decision.
- Notify Customer Service if your address changes.

Providence Health Plan has the responsibility to:

- Respect and honor your rights.
- Ensure timely access to appropriate health care Services.
- Enable you to see physicians or providers who meet your needs.
- Develop a variety of benefits to serve you well.
- Assure the ongoing quality of our providers and Services.
- Contract with providers who are capable, competent, and committed to excellence.
- Make it easy and convenient for you to Appeal any policy or decision that you believe prevents you from receiving appropriate care.
- Provide you with accurate up-to-date information about Providence Health Plan and In-Network Providers.
- Provide you with information and services designed to help you maintain good health and receive the greatest benefit from the services we offer.
- Ensure privacy and confidentiality of your medical records with access according to law.
- Ensure that your interests are well represented in decisions about Providence Health Plan policy and governance.
- Encourage physicians and providers to make medical decisions that are always in your best interest.

11.2 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 Clackamas County's Group Plan, you are entitled to certain rights and protections under Oregon law, which provides that all Plan participants are entitled to:

1. **Receive from Providence Health Plan information maintained about you by your Employer's group plan**
    - You are entitled within 30 days to access to recorded personal information, 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 10.1.
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 7, the Plan offers 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 7.2 of this Summary Plan Description. If the Member elects to seek external review under section 7.2.4, both the Plan and the Member will be bound by the Independent Review Organization (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 7.2.

    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 or an arbitrator, neither party shall under any circumstance be liable to the other for any special, incidental, or consequential damages, or for any tort liability (including any punitive or exemplary damages), in any way related to this Plan.

12. 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.

12.1 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 Clackamas County has determined satisfies the QMSCO standards set forth below.

"Procedures" means the Qualified Medical Child Support Order procedures as prescribed in this section.

"Designated Representative" means a representative designated by an Alternate Recipient to receive copies of notices that are sent to the Alternate Recipient with respect to an Order.

12.2 NOTICE UPON RECEIPT OF ORDER

Upon the receipt of any Order, Clackamas County 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.

12.3 NOTICE OF DETERMINATION

Within a reasonable period after its receipt of the Order, Clackamas County 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, the Order will not be considered to be a QMCSO.

12.4 ENROLLMENT OF ALTERNATE RECIPIENT

An Alternate Recipient with respect to an Order determined to be a QMCSO who properly submits the applicable enrollment forms to Clackamas County will become covered under the Plan to which such Order applies as soon as practicable after the applicable enrollment forms are received. An Alternate Recipient will be eligible to become covered under the Plan as of a particular date without regard to any open enrollment period restrictions otherwise applicable under the Plan.

12.5 COST OF COVERAGE

An Alternate Recipient will be treated as having been 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.

12.6 REIMBURSEMENT OF PLAN EXPENSES

Unless the terms of the Order provide otherwise, any payments to be from the Plan as reimbursement for group health expenses paid either by the Alternate Recipient, or by the custodial parent or legal guardian of the Alternate Recipient, will not be paid to the 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.

12.7 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.

12.8 TREATMENT OF NATIONAL MEDICAL SUPPORT NOTICE

If Clackamas County 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 Clackamas County to satisfy the QMCSO standards prescribed above, then the National Notice shall be deemed to be a QMSCO respect to such child.

Clackamas County, upon determining that the National Notice is a QMSCO, 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.

Clackamas County 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.

13. GENERAL PROVISIONS

13.1 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.

13.2 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.

13.3 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.

13.4 FAILURE TO PROVIDE INFORMATION OR PROVIDING INCORRECT OR INCOMPLETE INFORMATION

Members warrant that all information contained in applications, questionnaires, forms, or statements submitted to Clackamas County and to Providence Health Plan to be true, correct, and complete. If a Member willfully fails to provide information required to be provided under this Plan or knowingly provides incorrect or incomplete information, then the Member's rights may be terminated. See section 9.4.

13.5 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.

13.6 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.

13.7 LEGAL ACTION

No civil action may be brought under state or federal law to recover benefits from the Plan until receipt of a final decision under the Member Grievance and Appeal process specified in section 7.2 of the Summary Plan Description, unless the Member's benefits under the Plan are subject to the Employee Retirement Income Security Act (ERISA), in which case the Member is permitted either to bring a civil action under ERISA in federal court after receiving a decision from the First Level of Appeal or to bring such an action after receipt of a final grievance decision. An appeal from a final Grievance decision may lie with an Independent Review Organization (IRO). In the event a right to IRO review exists and the Member elects to seek such review, the IRO decision will be binding and final, as indicated in section 7.2.4. No civil action under ERISA or otherwise 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 7.2. If ERISA does not apply (see section 11.2), the action must be brought in Oregon state court, either in the Member's county of residence or such other county as mutually agreed upon between Member and the Plan. In general, ERISA applies if this is an employer-sponsored plan, other than a government plan or church plan.

13.8 LIMITATIONS AND 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 Clackamas County shall be paid solely in accordance with the terms and provisions of such plan, and nothing in this Plan shall operate or be construed in any way to modify, amend, or affect the terms and provisions of such other plan.

13.9 MEMBER RESPONSIBILITY

It is your responsibility to read and to understand the terms of this Plan. Neither Clackamas County nor Providence Health Plan will have any liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact Providence Health Plan. They will assist you in understanding and complying with the terms of the Plan.

13.10 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.

13.11 NON-TRANSFERABILITY OF BENEFITS

No person other than a Member is entitled to receive benefits under this Plan. Such right to benefits is nontransferable.

13.12 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 Clackamas County. No shareholder, director, officer, or employee of Clackamas County 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.

13.13 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 Clackamas County nor Providence Health Plan is liable for any claim or demand due to damages arising out of, or in any manner connected with, any injuries suffered by you while receiving such Services.

13.14 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.

13.15 NOTICE

Any notice required of Clackamas County or Providence Health Plan under this Plan shall be deemed to be sufficient if mailed to the Subscriber at the address appearing in 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, P.O. Box 3125, Portland, OR 97208.

13.16 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 6.1.1 regarding timely submission of claims.)

13.17 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. PHP'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 Clackamas County and Providence Health Plan.

13.18 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.

13.19 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 our 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.

13.20 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.

13.21 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 Clackamas County to deduct the overpayment from future benefit payments under this Plan.

13.22 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.

13.23 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.

13.24 SUGGESTIONS

You are encouraged to make suggestions to us. Suggestions may be oral or written and should be directed to the Customer Service Team at our administrative office.

13.25 VETERANS' RIGHTS

The Plan will provide benefits to employees 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) An employee who takes unpaid military leave, or who separates from the employment of Clackamas County 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 10. 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 employee's absence for the purpose of performing military service begins; or
    2. The date the employee fails to timely return to employment or reapply for a position with Clackamas County upon the completion of such military service.

13.26 WORKERS' COMPENSATION INSURANCE

This Plan is not in lieu of, and does not affect, any requirement for coverage under any workers' compensation act or similar law.

14. PLAN ADMINISTRATION

14.1 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.

14.2 PLAN INFORMATION

Plan Name: Clackamas County Peace Officers Association Personal Option Grandfathered Plan
Plan No. 100112
Employer ID No. 936002286

14.3 PLAN DATES

The Plan Year begins on January 1st and ends on December 31st

14.4 PLAN SPONSOR INFORMATION

Clackamas County
Benefits & Wellness Division
Public Services Building
2051 Kaen Road, Suite 310
Oregon City, OR 97045
503-655-8459

14.5 ADMINISTRATIVE SERVICES PROVIDED BY

Providence Health Plan
P.O. Box 4447
Portland, OR 97208-4447
800-878-4445

14.6 AGENT FOR SERVICE OF LEGAL PROCESS

Clackamas County
Office of the County Counsel
2051 Kaen Rd.
Oregon City, OR 97045

14.7 ADMINISTRATIVE SERVICES

The Employer 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.

14.7.1 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.

14.8 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.

14.9 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.

14.10 AMENDMENT OR TERMINATION OF PLAN

14.10.1 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.

14.10.2 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 Chair of the Board of County Commissioners or their designee shall be conclusive evidence of the adoption and effectiveness of the instrument.

14.10.3 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.

14.11 PROTECTED HEALTH INFORMATION

14.11.1 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 PHI obtained from Providence Health Plan 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:
    3. Directors of Human Resources;
    4. Benefit Managers;
    5. Benefit Analysts;
    6. Benefit Specialists; and
    7. 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.

14.11.2 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 14.11.1(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.

15. DEFINITIONS

The following are definitions of important capitalized terms used in this Summary Plan Description.

Adverse Benefit Determination
See section 7.

Ambulatory Surgery Center
Ambulatory Surgery Center means an independent medical facility that specializes in elective same-day or outpatient surgical procedures.

Annual
Annual means once per Calendar Year.

Appeal
See section 7.

Approved Clinical Trial
Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment or cancer or other life-threatening disease or condition and is one of the following:

- A federally funded or approved trial;
- A clinical trial conducted under an FDA investigational new drug application; or
- A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Authorized Representative
See section 7.

Benefit Summary
Benefit Summary means the documents with that title that are part of your Plan and summarize the benefit provisions under your Plan.

Calendar Year
Calendar Year means a 12-month time period beginning January 1st and ending December 31st.

Chemical Dependency
Chemical Dependency 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. Chemical Dependency does not mean an addiction to, or dependency on tobacco, tobacco products, or foods.

Clackamas County
Clackamas County means the entity that is the Sponsor of this Plan.

Clackamas County Peace Officers Association Personal Option Grandfathered Plan

Clackamas County Peace Officers Association Personal Option Grandfathered Plan means this Summary Plan Description and includes the provisions of the Benefit Summaries and any Endorsements, amendments and addendums that accompany this document.

Cochlear Implant

See section 4.12.11.

Coinsurance

Coinsurance means the dollar amount that you are responsible to pay to a health care provider, after your claim has been processed by Providence Health Plan. Your Coinsurance for a Covered Service is shown in the Benefit Summary and is a percentage of the charges for the Covered Service. Your Coinsurance will usually be less when you receive Covered Services from an In-Network Provider.

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 section 4;
2. Medically Necessary;
3. Not listed as an Exclusion in the Benefit Summary or in sections 4 and 5; 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.

Dependent

Dependent means a person who is supported by the Subscriber, or supported by the Subscriber's Spouse or Domestic Partner. See also Eligible Family Dependent.

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 with a member of the same sex; and
    - Has legally registered a Declaration of Domestic Partnership and obtained a Certificate of Registered Domestic Partnership in accordance with Oregon state law.
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 4.3.3).

Effective Date of Coverage
Effective Date of Coverage means the date upon which coverage under this Plan commences for a Member.

Eligibility Waiting Period
Eligibility Waiting Period means the period of employment, as specified in the Eligible Employee definition, that an otherwise Eligible Employee must complete before coverage will begin under this Plan. The Eligibility Waiting Period will not exceed 90 days. When the Eligibility Waiting Period is 90 days, coverage is effective on the 91st day. If an employee enrolls on a special enrollment date, any period before such special enrollment is not an Eligibility Waiting Period.

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 8.1.

1. Employment Status: Permanent. (On-call, temporary, substitute, and seasonal employees are not eligible.)
2. Employment Category/Class: Personal Option Peace Officer Association Employees, COBRA participants and Non-Medicare Eligible Early Retirees.
3. Work Hours: Peace Officers regularly scheduled for at least 20 hours per week. (Not applicable to COBRA and Non-Medicare Eligible Early Retiree.)
4. Eligibility Waiting Period: Two months.* A new Eligibility Waiting Period does not apply if an employee returns to work in eligible status from a period of layoff or leave of absence, provided that such period did not exceed 180 days. The Eligibility Waiting Period is also waived if an employee has continuously participated in COBRA continuation coverage during the layoff period and is rehired within 18 months from the date of layoff. (*Note: Effective July 1, 2021, the Eligibility Waiting Period for new employees hired on or after this date will be the first of the month following date of hire.)
5. Effective Date of Coverage: Active: First of the month following completion of the Eligibility Waiting Period. COBRA: First day following loss of Active coverage. Early Retiree: First of the month following retirement.
6. Location: Employees who work or reside in Oregon.
7. Leave of Absence Status: An otherwise Eligible Employee on an Employer-approved Leave of Absence shall remain eligible during the first six months of leave of absence. Absences extending beyond this period are subject to the COBRA provisions of this Summary Plan Description.
8. Layoff/Rehire: If the Eligible Employee is rehired within six months, the Eligibility Waiting Period is waived.

9. Retirement Status: Non-Medicare eligible retired employees are eligible.

Eligible Family Dependent

Eligible Family Dependent means:

1. The legally recognized Spouse or Domestic Partner of a Subscriber;
2. In relation to a Subscriber, the following individuals:
    a) A biological child, step-child, or legally adopted child;
    b) An unmarried grandchild for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support;
    c) A child placed for adoption with the Subscriber or Spouse;
    d) An unmarried individual for whom the Subscriber or Spouse is a legal guardian and for whom the Subscriber or Spouse provides at least 50% support; and
    e) A child for whom the Subscriber or Spouse is required to provide medical care under a Qualified Medical Child Support Order, as defined by federal law.

Placement for adoption means the assumption and retention by a Subscriber or Spouse, of a legal obligation for total or partial support of a child in anticipation of the adoption of the child (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption). Upon any termination of such legal obligations the placement for adoption shall be deemed to have terminated.

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:

a) Developmentally or physically disabled;
b) Incapable of self-sustaining employment prior to the limiting age; and
c) Unmarried.

Proof of incapacity must be provided to us 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. Thereafter, Providence Health Plan 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 Providence Health Plan, the individual's coverage will not continue beyond the last date of eligibility.

See section 8.2.4 for information on when and how to add a newborn to the Plan.

Emergency Medical Condition

See section 4.5.1.

Emergency Medical Screening Exams

See section 4.5.1.

Emergency Services

See section 4.5.1.

Employer
Employer means Clackamas County, an Oregon employer, and the Plan Sponsor.

Endorsement
Endorsement means a document that amends and is part of this Plan.

Essential Health Benefits
Essential Health Benefits means the general categories of services established under section 1302(b) of the Patient Protection and Affordable Care Act (PPACA) and applicable regulations:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental Health and substance use disorder (Substance Abuse) services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including dental and vision care.

Exclusion
Exclusion means an item or service that is not a Covered Service under the Plan.

Experimental/Investigational
Experimental/Investigational means Services for which current, prevailing, evidence-based, peer-reviewed medical literature does not demonstrate the safety and effectiveness of the Service for treating or diagnosing the condition or illness for which its use is proposed. In determining whether Services are Experimental/Investigational the Plan considers a variety of criteria, which include, but are not limited to, whether the Services are :

- Approved by the appropriate governmental regulatory body;
- Subject to review and approval of an institutional review board (IRB) or are currently offered through an approved clinical trial;
- Offered through an accredited and proficient provider in the United States;
- Reviewed and supported by national professional medical societies;
- Address the condition, injury, or complaint of the Member and show a demonstrable benefit for a particular illness or disease;
- Proven to be safe and efficacious; and
- Pose a significant risk to the health and safety of the Member.

The experimental/investigational status of a Service may be determined on a case-by-case basis. Providence Health Plan will retain documentation of the criteria used to define a Service as Experimental/Investigational and will make this available for review upon request.

Family Member
Family Member means a Dependent who is properly enrolled in and entitled to Covered

Services under this Plan.

Fiduciary
Fiduciary means a person entrusted to act on behalf of the Plan, consistent with the duties and obligations of plan administration as set forth under applicable law.

Global Fee
See section 4.13.2.

Grievance
See section 7.

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 Employee Retirement Income Security Act (ERISA).

Hearing Aid
See section 4.12.11.

Hearing Assistance Technology
See section 4.12.11.

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 Abuse or Mental Health disorders.

In-Network Provider

In-Network Provider means an Outpatient Surgical Facility, Home Health Provider, Hospital, Qualified Practitioner, Qualified Treatment Facility, Skilled Nursing Facility, or Pharmacy that has a written agreement with Providence Health Plan to participate as a health care provider for this Plan. For Native American Indian and Alaskan Native Members, Covered Services obtained through Indian Health Services are considered to be Covered Services obtained from an In-Network Provider.

In-Plan

In-Plan means the level of benefits specified in the Benefit Summary and this Summary Plan Description for Covered Services that are provided by an In-Network Provider.

Late Enrollee

Late Enrollee means a person eligible to enroll under a Special Enrollment Period, as described in section 8.3.

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 abuse 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 disorder covered by diagnostic categories listed in the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV) or the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

Non-Medicare Eligible Early Retiree
Non-Medicare Eligible Early Retiree means a Subscriber who retires from employment with Clackamas County and is eligible to enroll in this Plan.

Open Enrollment Period
Open Enrollment Period means a period during each Plan Year, as established by Clackamas County, 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 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 for this Plan.

Out-of-Plan
Out-of-Plan means the level of benefits specified in the Benefit Summary and this Summary Plan Description for Covered Services provided by Out-of-Network Providers.

Out-of-Pocket Maximum
See section 3.13.1.

Outpatient Surgical Facility
Outpatient surgical facility means any licensed public or private establishment that has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgery. It does NOT provide Services or accommodations for patients to stay overnight.

Participating Pharmacy
Participating Pharmacy means pharmacy that has a signed contract 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.

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 Qualified Practitioner specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Primary Care Provider.

(Note: Not all Qualified Practitioners are Primary Care Providers. To obtain a listing of In-Network Primary Care Providers, please see the Provider Directory online or call Customer Service.)

Plan

Plan means the Clackamas County group health plan, as set forth in this document, the Summary Plan Description, and includes the provisions of any Benefit Summary 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.

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 Providence Health Plan's 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, additional information may be required about the Member's condition and/or the Services requested. Providence Health Plan 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 Plan. Services that require Prior Authorization are shown in section 3.7.

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 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, 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 corrects a congenital deformity or anomaly that results in a functional impairment.

Retail Health Clinic
Retail Health Clinic means a walk-in clinic located in a retail setting such as a store, supermarket, or pharmacy that treats uncomplicated minor illnesses and injuries.

Service
Service means a health care related procedure, surgery, consultation, advice, diagnosis, referral, treatment, supply, medication, prescription drug, device or technology that is provided to a Member by a Qualified Practitioner.

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 or non-Medicare Eligible Early Retiree of Clackamas County who is eligible for benefits and is properly enrolled in accordance with the provisions of this Summary Plan Description.

Summary Plan Description (SPD)
Summary Plan Description (SPD) means the description of the Plan as contained in this document, and includes the provisions of any Benefit Summary, any Endorsements, amendments and addendums that accompany this document, and those policies maintained by Providence Health Plan which clarify any of these documents.

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
Urgent Care means Services that are provided for unforeseen, non-life threatening, minor illnesses and injuries which require immediate attention, such as ear, nose and throat infections and minor sprains and lacerations.

Urgent Care Covered Services are provided when your medical condition meets the guidelines for Urgent Care that have been established by Providence Health Plan. Covered Services do NOT include Services for the inappropriate use of an Urgent Care facility, such as: services that do not require immediate attention, routine check-ups, follow-up care, and prescription drug requests.

Usual, Customary and Reasonable (UCR)
When a Service is provided by an In-Network Provider, UCR means charges based on the fee that 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 determined, in Providence Health Plan's reasonable discretion, based on the lesser of:

1. The fee a professional provider usually charges for a given Service;
2. A fee which falls within the range of usual charges for a given Service billed by most professional providers in the same locality or region who have similar training and experience;
3. A fee which is based upon a percentage of the Medicare allowable amount;
4. A fee which is prevalent or which would not be considered excessive in a particular case because of unusual circumstances; or
5. The fee determined by comparing charges for similar Services to a regional or national database adjusted to the geographical area where the Service was performed.

UCR charges do not include sales taxes, handling fees and similar surcharges, and such taxes, fees and surcharges are not covered expenses.

Virtual Visit
Virtual Visit means a visit with an In-Network Provider using secure internet technology:

- Phone and Video Visit:
- Phone and Video Visit means a Medically Necessary and appropriate consultation through phone and video with an In-Network Provider using Providence Health Plan

approved secure technology. A Phone and Video Visit must relate to the treatment of a covered illness or injury (see also section 4.3.2).

Women's Health Care Provider

Women's Health Care Provider means an obstetrician or gynecologist, some Primary Care Providers (if they are licensed to provide obstetrical services), physician assistant specializing in women's health, advanced registered nurse practitioner specialist in women's health, certified nurse midwife, or licensed direct entry midwife practicing within the applicable lawful scope of practice.

16. NON-DISCRIMINATION STATEMENT

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: 711 :TTY).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

ATTENTION: Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)

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 Clackamas County self-funded Employee Health Benefit Plan, Clackamas County Peace Officers Association Personal Option Grandfathered 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 Clackamas County'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, 2021.

By: _____

Printed Name: _____

Title: _____

Company: _____

Date: _____

Administered by

PROVIDENCE
Health Plan

Our Mission

As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Our Values

Compassion | Dignity | Justice | Excellence | Integrity

Questions? We're here to help.

Speak to one of our Customer Service representatives at 503-574-7500 or 800-878-4445 (TTY: 771); 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.

©2020 Providence Health Plan. All rights reserved.

Clackamas Co POA Personal Option GF SPD
Effective January 01, 2021
Administered by Providence Health Plan

CLACKAMAS COUNTY

Department of Assessment and Taxation

TAMI LITTLE
COUNTY ASSESSOR

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of Amendment #3 with Pictometry International Corporation, dba EagleView
for the Professional Services of Oblique and Orthogonal Aerial Imagery

Purpose/Outcomes	To amend our current oblique and orthogonal aerial imagery contract to meet our need for integration of Geographical Information Services (GIS) data into our Computer Assisted Mass Appraisal system (CAMA). This amendment will change our contract from one flight every three years to one flight per year. This change to annual flights saves $85,736 per flight by reducing our per flight cost from $368,429 to $282,693. Oblique imagery is required for compliance with the appraisal definition established by the International Association of Assessing Officers in order to perform desk reviews.
Dollar Amount and Fiscal Impact	Original Contract approved for 2 flights for a total of $737,268.50. Amendment #2 added additional licenses for use by the County Sheriff at $1,100 per year. Amendment #3 corrects the original 2nd Imagery cost and adds 5 additional annual imagery services for a total of $1,327,729. The total Contract Compensation shall not exceed **$2,070,497.50**.
Funding Source	General Fund, Assessment & Taxation Division Budget, 1003-100302-100-48140.
Duration	From execution though June 30, 2027
Previous Board Action	Approval of the original Contract on October 4, 2018
Strategic Plan Alignment	1. Grow a Vibrant Economy 2. Build a Strong Infrastructure 3. Build Public Trust through Good Government
Procurement Review	1. Was this item processed through Procurement? ☒ yes ☐ no 2. If no, provide a brief explanation:
Counsel Review	Reviewed Date: 11-9-2021 ARN
Contact Person	Tami Little, Assessor, 503-655-8302
Contract #	1411

Background:

In 2018, The Department of Assessment & Taxation was in need of GIS integration into our CAMA system. The new technology helped us develop better and more efficient mass appraisal solutions. We compared data from each flight with current inventory at a parcel level, aiding our ability to find both missing and demolished buildings. This improves the accuracy of the tax roll and helps meet our strategic goal of reducing omitted property, a growing issue that needs addressed to achieve and maintain fair and equitable valuations. We added 1 FTE in 2019 to lead the Pictometry project.

CLACKAMAS COUNTY

Department of Assessment and Taxation

TAMI LITTLE
COUNTY ASSESSOR

Using the imagery from our first flight, we added a one-time amount of $420,996 in back taxes from omitted property and an additional $165,174 to the 2020-21 tax year that will grow 3% each year going forward.

Our initial contract called for one flight every three years. However, since inception of this project we have known annual flights would benefit us more than flights every three years. We are required to value property on an annual basis and need current data in order to accomplish that. The value added from our first flight further demonstrates the need to change our flight schedule to an annual basis.

This amendment adds annual flights through June 2027. The overall cost of the contract is increasing, but the cost per flight is decreasing by $85,736. This amendment provides a cost savings of $514,416 on six flights and gives us updated imagery each year.

A one-page report with details of the value and taxes added to the 2020-21 Tax Roll is available upon request.

Other county departments including the Sheriff, DTD and Forestry, in addition the City of Molalla, are using this imagery. It was invaluable in assisting EOC/DTD staff working the 2020 wildfires.

Procurement Process:
The original Contract was obtained through a Sole Source process. This Amendment is in accordance with LCRB C-047-0800(b) for an unanticipated amendment.

Recommendation:
Staff respectfully recommends that the Board approve and execute Amendment #3 for the contract with Pictometry International Corporation, dba EagleView for the Professional Services of Oblique and Orthogonal Aerial Imagery.

Sincerely,

Tami Little

Tami Little
County Assessor

Placed on the BCC Agenda _____ by Procurement and Contract Services

AMENDMENT NO. 3 TO AGREEMENT DATED OCTOBER 15, 2018 BETWEEN PICTOMETRY INTERNATIONAL CORP. ("PICTOMETRY") AND CLACKAMAS COUNTY, OR ("CUSTOMER")

1. This Amendment No. 3, including all Sections and Appendices referenced herein (collectively, this "Amendment") is entered into by and between Pictometry and Customer and supplements and modifies the terms of the Agreement dated October 15, 2018 as, to the extent applicable, previously modified by addenda or amendments thereto (collectively, the "Agreement"). Any purchase order or similar document issued by Customer in connection with this Amendment is issued solely for Customer's internal administrative purposes and the terms and conditions set forth on such purchase order shall be of no force or effect as between the parties. To the extent that there is any inconsistency between the terms set forth in this Amendment and those set forth in the Agreement, the terms set forth in this Amendment shall prevail.

   Section A: Product Descriptions, Prices and Payment Terms
   Appendix 1: Photogrammetric Product Specifications
   Map(s)

2. MODIFICATIONS TO AGREEMENT:
   a. The Second Project products, pricing, product parameters and payment schedule set forth in Section A of the Agreement are replaced in their entirety with the Second Project products, pricing, product parameters and payment schedule set forth in Section A of this Amendment.
   b. The products, pricing, product parameters and payment schedule pertaining to the Third, Fourth, Fifth, Sixth, and Seventh Projects set forth in Section A of this Amendment shall be added to the Agreement and subject to the terms and conditions set forth in the Agreement.
   c. All references to "Applicable Terms and Conditions" in the individual Product Descriptions set forth in Section A of this Amendment shall refer to the terms and conditions set forth in the Agreement.
   d. Appendix 1: Photogrammetric Product Specifications and the Map attached to this Amendment, which pertains to the Second, Third, Fourth, Fifth, Sixth, and Seventh Projects, shall be added to the Agreement.
   e. All other terms and conditions set forth in the Agreement shall remain in full force and effect.

3. All notices under this Agreement shall be in writing and shall be sent to the following respective addresses:

CUSTOMER NOTICE ADDRESS
150 Beavercreek Road
Oregon City, OR 97045
Attn: Tami Little , County Assessor
Phone: (503) 655-8302 Fax:

PICTOMETRY NOTICE ADDRESS
25 Methodist Hill Drive
Rochester, New York 14623
Attn: General Counsel
Phone: (585) 486-0093 Fax: (585) 486-0098

   Either party may change their respective notice address by giving written notice of such change to the other party at the other party's then-current notice address. Notices shall be given by any of the following methods: personal delivery; reputable express courier providing written receipt; or postage-paid certified or registered United States mail, return receipt requested. Notice shall be deemed given when actually received or when delivery is refused.

This Amendment shall become effective upon execution by duly authorized officers of Customer and Pictometry and receipt by Pictometry of such fully executed document.

[Signature page follows]

PARTIES:

CUSTOMER	PICTOMETRY
CLACKAMAS COUNTY, OR	PICTOMETRY INTERNATIONAL CORP.
	a Delaware corporation
SIGNATURE:	SIGNATURE: Robert Locke
NAME: Tootie Smith	NAME: Robert Locke
TITLE: Chair	TITLE: President
DATE:	EXECUTION DATE: 11/9/2021
Recording Secretary	DATE OF RECEIPT (EFFECTIVE DATE):

Approved as to Form:

Andrew Naylor

Digitally signed by Andrew Naylor
Date: 2021.11.09 16:43:54 -08'00'

County Counsel , Date

SECTION A

PRODUCT DESCRIPTIONS, PRICES AND PAYMENT TERMS

Pictometry International Corp.
25 Methodist Hill Drive
Rochester, New York 14623

ORDER #
C26497792

BILL TO
Clackamas County, OR
Tami Little, County Assessor
150 Beavercreek Road Oregon City, OR 97045
(503) 655-8302
tamilit@clackamas.us

SHIP TO
Clackamas County, OR
Tami Little, County Assessor
150 Beavercreek Road Oregon City, OR 97045
(503) 655-8302
tamilit@clackamas.us

CUSTOMER ID	SALES REP	FREQUENCY OF PROJECT
A118146	dwalt	Annual

SECOND PROJECT

QTY	PRODUCT NAME	PRODUCT DESCRIPTION	LIST PRICE	DISCOUNT PRICE (%)	AMOUNT[1]
919	Reveal Essentials+ Neighborhood	Provides ortho and oblique imagery at a Neighborhood level. Deliverables include measurable oblique and ortho imagery at a neighborhood resolutions. Color balanced orthomosaic imagery is generated by a fully automated photogrammetric process and delivered digitally in various formats with the associated metadata. Applicable Terms and Conditions: Delivered Content Terms and Conditions of Use Product Parameters: *Leaf:* Leaf Off: Less than 30% leaf cover	$ 160.00	$ 144.00 (10% - Long Term Incentive Discount)	$ 132,336.00
249	Reveal Essentials+ Property	Provides high resolution ortho and oblique imagery at a Property level. Deliverables include measurable oblique and ortho imagery at a property resolutions. Color balanced orthomosaic imagery is generated by a fully automated photogrammetric process and delivered digitally in various formats with the associated metadata. Applicable Terms and Conditions: Delivered Content Terms and Conditions of Use Product Parameters: *Leaf:* Leaf Off: Less than 30% leaf cover	$ 400.00	$ 342.00 (14.5% - Long Term Incentive Discount)	$ 85,158.00
162,000	ChangeFinder - Change Detection; Digital Parcel File Provided	Existing building outlines from a specified older imagery source are updated and classified relative to the most-nadir single-frame orthogonal image in a specified, newer Pictometry imagery source. Pictometry delivers updated digital building outlines from the newer imagery source and their classification attributes in shapefile and geodatabase formats. Coverage includes only locations specified in a single, customer-provided digital parcel shapefile. Parcels in the specified locations must be generally contiguous. All Pictometry imagery to be used must be licensed or owned by the customer. Final invoiced amount will be adjusted for the actual quantity of records in the parcel file used for production. Use of older non-Pictometry-sourced building outline data requires acceptance in advance. Applicable Terms and Conditions: Delivered Content Terms and Conditions of Use Product Parameters: *Data Source – Base:* Pictometry Outlines *Data Source Year – Base:*	$ 0.35		$ 56,700.00

		2021 *Data Source – Comparison:* Pictometry Imagery *Data Source Year – Comparison:* 2022 *Deck Identification:* Marked with a Point *Regional Status Report Requested:* *Modified Technical Specifications:* *Parameter Changes* Prior to commencement of production, Customer may make changes to these product parameters by providing Pictometry with written authorization (email being acceptable).			
1	CONNECT Gov 100 Package	CONNECT Gov 100 Package provides Customer with access to and use of Pictometry Connect - CA - 100, Pictometry Connect View - CA, and CONNECT ImageService CA as described elsewhere in this Agreement. Applicable Terms and Conditions: Online Services General Terms and Conditions;Software License Agreement	$ 5,000.00		$ 5,000.00
1	FutureView Adv Training	Full conference registration to advanced training designed to maximize deployment. Includes hotel room for up to three nights, event registration, and round-trip airfare up to $500. Customer will be provided with discount code to complete FutureView registration. (Air Travel Restrictions - 30 day advance purchase for airfare, per person round trip airfare at standard coach class rates through Pictometry's travel provider only.) Must be redeemed within three years of agreement execution date. Applicable Terms and Conditions: Order Form	$ 2,499.00		$ 2,499.00
1	ChangeFinder - Project Fee	This is a flat fee per project. One project set-up fee is required for each Change Detection, Change Detection and Building Outlines, or Building Outline line item in the order. Applicable Terms and Conditions: Order Form	$ 1,000.00		$ 1,000.00
1	Pictometry Connect - EarlyAccess	Pictometry Connect - EarlyAccess provides authorized users the ability to login and access the imagery, as specified elsewhere in this agreement, immediately following its preliminary processing and quality control checks and prior to its final processing. Early Access imagery will become available in CONNECT Explorer incrementally as it is processed and it will remain available until final, fully processed imagery is made available through other means. This offering requires an active Pictometry CONNECT account and the current purchase of access to an imagery product. Applicable Terms and Conditions: Online Services General Terms and Conditions	$ 10,000.00	$ 0.00 (100%)	$ 0.00
1	RapidAccess - Disaster Response Program	RapidAccess - Disaster Response Program is an emergency response program offering flights after an emergency or disaster. Refer to the attached detailed description of the Disaster Response Program. Applicable Terms and Conditions: Order Form	$ 0.00		$ 0.00
1	Pictometry for Esri Web AppBuilder	Pictometry for Esri Web AppBuilder is a server based widget for installation on Customer's server that allows users with valid Pictometry Connect accounts to access oblique and orthogonal imagery within web applications authored using Web AppBuilder for ArcGIS (Developer Edition) available separately from Esri. Requires a Pictometry Connect account.	$ 1,990.00	$ 0.00 (100%)	$ 0.00

		Applicable Terms and Conditions: Software License Agreement Product Parameters: *Server Integration:* Web AppBuilder (Both Visualization and Analytics)			
1	Oblique Imagery Bundle w/One (1) Year of EFS Maint & Support	Includes digital copy of the Licensed Documentation for the License Software, two (2) End User Training Sessions, one (1) Advanced User Technical Training, one (1) Administration / IT Training Session, five (5) hours of telephone support, one copy of Pictometry Electronic Field Study (EFS) software, latest version, on the storage media specified herein, and access to download updated versions of the EFS Licensed Software for a period of one years from the initial date of shipment of the EFS software, along with a copy of the updated documentation. Applicable Terms and Conditions: Software License Agreement	$ 0.00		$ 0.00
919	Reveal Orthomosaic - Combined	This product represents a single orthomosaic, combining tiles of multiple resolutions with the best-available resolution preferred Applicable Terms and Conditions: Delivered Content Terms and Conditions of Use Product Parameters: *Leaf:* Leaf Off: Less than 30% leaf cover	$ 0.00		$ 0.00
1	Pictometry Connect - CA - 100	Pictometry Connect - CA - 100 (Custom Access) provides up to 100 concurrent authorized users the ability to login and access the Pictometry-hosted custom imagery libraries specified elsewhere in this Agreement via a web-based, server-based or desktop integration. The default deployment is through web-based Pictometry Connect. Term commences on date of activation. The quantity represents the number of years in the Connect term. Applicable Terms and Conditions: Online Services General Terms and Conditions;Software License Agreement Product Parameters: *Admin User Name:* Tami Little *Admin User Email:* tamilit@clackamas.us	$ 3,300.00	$ 0.00 (100%)	$ 0.00
1	Pictometry Connect View - CA	Pictometry Connect View - CA (Custom Access) provides visualization-only access to the Pictometry-hosted custom imagery libraries specified elsewhere in this Agreement via a web application or server based integration. Requires a customer-provided web application or server based application. With respect to imagery available through this product to third parties or the Public, Pictometry reserves the right to reduce the resolution of the imagery available. Term commences on date of activation. The quantity represents the number of years in the Connect term. Applicable Terms and Conditions: Web Visualization Offering Terms and Conditions Product Parameters: *Admin User Name:* Tami Little	$ 750.00	$ 0.00 (100%)	$ 0.00

		Admin User Email: tamilit@clackamas.us			
1	CONNECT ImageService CA	Connect Image Service - CA (Custom Access) provides access via a secure web mapping service to existing orthomosaics available within Customer's Connect account. This service allows use by Customer each calendar month of a total number of image request transactions equal to the product resulting from multiplying (a) the number of concurrent users authorized to use the Connect Image Service pursuant to this Agreement, by (b) 1500 (such product being the "Monthly Image Request Limit"). To the extent use of the Connect Image Service pursuant to this Agreement results in a total number of image request transactions in excess of the Monthly Image Request Limit, Pictometry may review the usage with Customer, increase the price for Customer's Connect Image Service with Customer's consent or, in Pictometry's discretion, suspend further access by Customer to the Connect Image Service. This offering is provided solely for internal use within Customer's organization. Customer must maintain an active paid Pictometry Connect account in order to utilize the Connect Image Service. Applicable Terms and Conditions: Online Services General Terms and Conditions	$ 2,000.00	$ 0.00 (100%)	$ 0.00
				SUBTOTAL	$282,693.00

THIRD PROJECT

QTY	PRODUCT NAME	PRODUCT DESCRIPTION	LIST PRICE	DISCOUNT PRICE (%)	AMOUNT[1]
919	Reveal Essentials+ Neighborhood	Provides ortho and oblique imagery at a Neighborhood level. Deliverables include measurable oblique and ortho imagery at a neighborhood resolutions. Color balanced orthomosaic imagery is generated by a fully automated photogrammetric process and delivered digitally in various formats with the associated metadata. Applicable Terms and Conditions: Delivered Content Terms and Conditions of Use Product Parameters: *Leaf:* Leaf Off: Less than 30% leaf cover	$ 160.00	$ 144.00 (10% - Long Term Incentive Discount)	$ 132,336.00
249	Reveal Essentials+ Property	Provides high resolution ortho and oblique imagery at a Property level. Deliverables include measurable oblique and ortho imagery at a property resolutions. Color balanced orthomosaic imagery is generated by a fully automated photogrammetric process and delivered digitally in various formats with the associated metadata. Applicable Terms and Conditions: Delivered Content Terms and Conditions of Use Product Parameters: *Leaf:* Leaf Off: Less than 30% leaf cover	$ 400.00	$ 342.00 (14.5% - Long Term Incentive Discount)	$ 85,158.00
162,000	ChangeFinder - Change Detection; Digital Parcel File Provided	Existing building outlines from a specified older imagery source are updated and classified relative to the most-nadir single-frame orthogonal image in a specified, newer Pictometry imagery source. Pictometry delivers updated digital building outlines from the newer imagery source and their classification attributes in shapefile and geodatabase formats. Coverage includes only locations specified in a single, customer-provided digital parcel shapefile. Parcels in the specified locations must be generally contiguous. All Pictometry imagery to be used must be licensed or owned by the customer. Final invoiced amount will be adjusted for the actual quantity of records in the parcel file used for production. Use of older non-Pictometry-sourced building outline data requires acceptance in advance.	$ 0.35		$ 56,700.00

		Applicable Terms and Conditions: Delivered Content Terms and Conditions of Use Product Parameters: *Data Source – Base:* Pictometry Outlines *Data Source Year – Base:* 2022 *Data Source – Comparison:* Pictometry Imagery *Data Source Year – Comparison:* 2023 *Deck Identification:* Marked with a Point *Regional Status Report Requested:* *Modified Technical Specifications:* *Parameter Changes* Prior to commencement of production, Customer may make changes to these product parameters by providing Pictometry with written authorization (email being acceptable).			
1	CONNECT Gov 100 Package	CONNECT Gov 100 Package provides Customer with access to and use of Pictometry Connect - CA - 100, Pictometry Connect View - CA, and CONNECT ImageService CA as described elsewhere in this Agreement. Applicable Terms and Conditions: Online Services General Terms and Conditions;Software License Agreement	$ 5,000.00		$ 5,000.00
1	FutureView Adv Training	Full conference registration to advanced training designed to maximize deployment. Includes hotel room for up to three nights, event registration, and round-trip airfare up to $500. Customer will be provided with discount code to complete FutureView registration. (Air Travel Restrictions - 30 day advance purchase for airfare, per person round trip airfare at standard coach class rates through Pictometry's travel provider only.) Must be redeemed within three years of agreement execution date. Applicable Terms and Conditions: Order Form	$ 2,499.00		$ 2,499.00
1	ChangeFinder - Project Fee	This is a flat fee per project. One project set-up fee is required for each Change Detection, Change Detection and Building Outlines, or Building Outline line item in the order. Applicable Terms and Conditions: Order Form	$ 1,000.00		$ 1,000.00
919	Reveal Orthomosaic - Combined	This product represents a single orthomosaic, combining tiles of multiple resolutions with the best-available resolution preferred Applicable Terms and Conditions: Delivered Content Terms and Conditions of Use Product Parameters: *Leaf:* Leaf Off: Less than 30% leaf cover	$ 0.00		$ 0.00
1	Oblique Imagery Bundle w/One (1) Year of EFS Maint & Support	Includes digital copy of the Licensed Documentation for the License Software, two (2) End User Training Sessions, one (1) Advanced User Technical Training, one (1) Administration / IT Training Session, five (5) hours of telephone support, one copy of Pictometry Electronic Field Study (EFS) software, latest version, on the storage media specified herein, and access to download updated versions of the EFS Licensed Software for a period of one years from the initial date of shipment of the EFS software, along with a copy of the updated documentation.	$ 0.00		$ 0.00

		Applicable Terms and Conditions: Software License Agreement			
1	RapidAccess - Disaster Response Program	RapidAccess - Disaster Response Program is an emergency response program offering flights after an emergency or disaster. Refer to the attached detailed description of the Disaster Response Program. Applicable Terms and Conditions: Order Form	$ 0.00		$ 0.00
1	Pictometry Connect - EarlyAccess	Pictometry Connect - EarlyAccess provides authorized users the ability to login and access the imagery, as specified elsewhere in this agreement, immediately following its preliminary processing and quality control checks and prior to its final processing. Early Access imagery will become available in CONNECT Explorer incrementally as it is processed and it will remain available until final, fully processed imagery is made available through other means. This offering requires an active Pictometry CONNECT account and the current purchase of access to an imagery product. Applicable Terms and Conditions: Online Services General Terms and Conditions	$ 10,000.00	$ 0.00 (100%)	$ 0.00
1	Pictometry Connect - CA - 100	Pictometry Connect - CA - 100 (Custom Access) provides up to 100 concurrent authorized users the ability to login and access the Pictometry-hosted custom imagery libraries specified elsewhere in this Agreement via a web-based, server-based or desktop integration. The default deployment is through web-based Pictometry Connect. Term commences on date of activation. The quantity represents the number of years in the Connect term. Applicable Terms and Conditions: Online Services General Terms and Conditions;Software License Agreement Product Parameters: *Admin User Name:* Tami Little *Admin User Email:* tamilit@clackamas.us	$ 3,300.00	$ 0.00 (100%)	$ 0.00
1	CONNECT ImageService CA	Connect Image Service - CA (Custom Access) provides access via a secure web mapping service to existing orthomosaics available within Customer's Connect account. This service allows use by Customer each calendar month of a total number of image request transactions equal to the product resulting from multiplying (a) the number of concurrent users authorized to use the Connect Image Service pursuant to this Agreement, by (b) 1500 (such product being the "Monthly Image Request Limit"). To the extent use of the Connect Image Service pursuant to this Agreement results in a total number of image request transactions in excess of the Monthly Image Request Limit, Pictometry may review the usage with Customer, increase the price for Customer's Connect Image Service with Customer's consent or, in Pictometry's discretion, suspend further access by Customer to the Connect Image Service. This offering is provided solely for internal use within Customer's organization. Customer must maintain an active paid Pictometry Connect account in order to utilize the Connect Image Service. Applicable Terms and Conditions: Online Services General Terms and Conditions	$ 2,000.00	$ 0.00 (100%)	$ 0.00
1	Pictometry Connect View - CA	Pictometry Connect View - CA (Custom Access) provides visualization-only access to the Pictometry-hosted custom imagery libraries specified elsewhere in this Agreement via a web application or server based integration. Requires a customer-provided web application or server based application. With respect to imagery available through this product to third parties or the Public, Pictometry reserves the right to reduce the resolution of the imagery available.	$ 750.00	$ 0.00 (100%)	$ 0.00

		Term commences on date of activation. The quantity represents the number of years in the Connect term. Applicable Terms and Conditions: Web Visualization Offering Terms and Conditions Product Parameters: *Admin User Name:* Tami Little *Admin User Email:* tamilit@clackamas.us			
				SUBTOTAL	$282,693.00

FOURTH PROJECT					
QTY	**PRODUCT NAME**	**PRODUCT DESCRIPTION**	**LIST PRICE**	**DISCOUNT PRICE (%)**	**AMOUNT[1]**
919	Reveal Essentials+ Neighborhood	Provides ortho and oblique imagery at a Neighborhood level. Deliverables include measurable oblique and ortho imagery at a neighborhood resolutions. Color balanced orthomosaic imagery is generated by a fully automated photogrammetric process and delivered digitally in various formats with the associated metadata. Applicable Terms and Conditions: Delivered Content Terms and Conditions of Use Product Parameters: *Leaf:* Leaf Off: Less than 30% leaf cover	$ 160.00	$ 144.00 (10% - Long Term Incentive Discount)	$ 132,336.00
249	Reveal Essentials+ Property	Provides high resolution ortho and oblique imagery at a Property level. Deliverables include measurable oblique and ortho imagery at a property resolutions. Color balanced orthomosaic imagery is generated by a fully automated photogrammetric process and delivered digitally in various formats with the associated metadata. Applicable Terms and Conditions: Delivered Content Terms and Conditions of Use Product Parameters: *Leaf:* Leaf Off: Less than 30% leaf cover	$ 400.00	$ 342.00 (14.5% - Long Term Incentive Discount)	$ 85,158.00
162,000	ChangeFinder - Change Detection; Digital Parcel File Provided	Existing building outlines from a specified older imagery source are updated and classified relative to the most-nadir single-frame orthogonal image in a specified, newer Pictometry imagery source. Pictometry delivers updated digital building outlines from the newer imagery source and their classification attributes in shapefile and geodatabase formats. Coverage includes only locations specified in a single, customer-provided digital parcel shapefile. Parcels in the specified locations must be generally contiguous. All Pictometry imagery to be used must be licensed or owned by the customer. Final invoiced amount will be adjusted for the actual quantity of records in the parcel file used for production. Use of older non-Pictometry-sourced building outline data requires acceptance in advance. Applicable Terms and Conditions: Delivered Content Terms and Conditions of Use Product Parameters: *Data Source – Base:* Pictometry Outlines *Data Source Year – Base:* 2023 *Data Source – Comparison:* Pictometry Imagery *Data Source Year – Comparison:* 2024 *Deck Identification:* Marked with a Point *Regional Status Report Requested:*	$ 0.35		$ 56,700.00

		Modified Technical Specifications: *Parameter Changes* Prior to commencement of production, Customer may make changes to these product parameters by providing Pictometry with written authorization (email being acceptable).			
1	CONNECT Gov 100 Package	CONNECT Gov 100 Package provides Customer with access to and use of Pictometry Connect - CA - 100, Pictometry Connect View - CA, and CONNECT ImageService CA as described elsewhere in this Agreement. Applicable Terms and Conditions: Online Services General Terms and Conditions;Software License Agreement	$ 5,000.00		$ 5,000.00
1	FutureView Adv Training	Full conference registration to advanced training designed to maximize deployment. Includes hotel room for up to three nights, event registration, and round-trip airfare up to $500. Customer will be provided with discount code to complete FutureView registration. (Air Travel Restrictions - 30 day advance purchase for airfare, per person round trip airfare at standard coach class rates through Pictometry's travel provider only.) Must be redeemed within three years of agreement execution date. Applicable Terms and Conditions: Order Form	$ 2,499.00		$ 2,499.00
1	ChangeFinder - Project Fee	This is a flat fee per project. One project set-up fee is required for each Change Detection, Change Detection and Building Outlines, or Building Outline line item in the order. Applicable Terms and Conditions: Order Form	$ 1,000.00		$ 1,000.00
1	Pictometry Connect - EarlyAccess	Pictometry Connect - EarlyAccess provides authorized users the ability to login and access the imagery, as specified elsewhere in this agreement, immediately following its preliminary processing and quality control checks and prior to its final processing. Early Access imagery will become available in CONNECT Explorer incrementally as it is processed and it will remain available until final, fully processed imagery is made available through other means. This offering requires an active Pictometry CONNECT account and the current purchase of access to an imagery product. Applicable Terms and Conditions: Online Services General Terms and Conditions	$ 10,000.00	$ 0.00 (100%)	$ 0.00
1	RapidAccess - Disaster Response Program	RapidAccess - Disaster Response Program is an emergency response program offering flights after an emergency or disaster. Refer to the attached detailed description of the Disaster Response Program. Applicable Terms and Conditions: Order Form	$ 0.00		$ 0.00
1	Oblique Imagery Bundle w/One (1) Year of EFS Maint & Support	Includes digital copy of the Licensed Documentation for the License Software, two (2) End User Training Sessions, one (1) Advanced User Technical Training, one (1) Administration / IT Training Session, five (5) hours of telephone support, one copy of Pictometry Electronic Field Study (EFS) software, latest version, on the storage media specified herein, and access to download updated versions of the EFS Licensed Software for a period of one years from the initial date of shipment of the EFS software, along with a copy of the updated documentation. Applicable Terms and Conditions: Software License Agreement	$ 0.00		$ 0.00

919	Reveal Orthomosaic - Combined	This product represents a single orthomosaic, combining tiles of multiple resolutions with the best-available resolution preferred Applicable Terms and Conditions: Delivered Content Terms and Conditions of Use Product Parameters: *Leaf:* Leaf Off: Less than 30% leaf cover	$ 0.00		$ 0.00
1	Pictometry Connect - CA - 100	Pictometry Connect - CA - 100 (Custom Access) provides up to 100 concurrent authorized users the ability to login and access the Pictometry-hosted custom imagery libraries specified elsewhere in this Agreement via a web-based, server-based or desktop integration. The default deployment is through web-based Pictometry Connect. Term commences on date of activation. The quantity represents the number of years in the Connect term. Applicable Terms and Conditions: Online Services General Terms and Conditions;Software License Agreement Product Parameters: *Admin User Name:* Tami Little *Admin User Email:* tamilit@clackamas.us	$ 3,300.00	$ 0.00 (100%)	$ 0.00
1	Pictometry Connect View - CA	Pictometry Connect View - CA (Custom Access) provides visualization-only access to the Pictometry-hosted custom imagery libraries specified elsewhere in this Agreement via a web application or server based integration. Requires a customer-provided web application or server based application. With respect to imagery available through this product to third parties or the Public, Pictometry reserves the right to reduce the resolution of the imagery available. Term commences on date of activation. The quantity represents the number of years in the Connect term. Applicable Terms and Conditions: Web Visualization Offering Terms and Conditions Product Parameters: *Admin User Name:* Tami Little *Admin User Email:* tamilit@clackamas.us	$ 750.00	$ 0.00 (100%)	$ 0.00
1	CONNECT ImageService CA	Connect Image Service - CA (Custom Access) provides access via a secure web mapping service to existing orthomosaics available within Customer's Connect account. This service allows use by Customer each calendar month of a total number of image request transactions equal to the product resulting from multiplying (a) the number of concurrent users authorized to use the Connect Image Service pursuant to this Agreement, by (b) 1500 (such product being the "Monthly Image Request Limit"). To the extent use of the Connect Image Service pursuant to this Agreement results in a total number of image request transactions in excess of the Monthly Image Request Limit, Pictometry may review the usage with Customer, increase the price for Customer's Connect Image Service with Customer's consent or, in Pictometry's discretion, suspend further access by Customer to the Connect Image Service. This offering is provided solely for internal use within Customer's organization. Customer must maintain an active paid Pictometry Connect account in order to utilize the Connect Image Service. Applicable Terms and Conditions: Online Services General Terms and Conditions	$ 2,000.00	$ 0.00 (100%)	$ 0.00
				SUBTOTAL	$282,693.00

FIFTH PROJECT					
QTY	**PRODUCT NAME**	**PRODUCT DESCRIPTION**	**LIST PRICE**	**DISCOUNT PRICE (%)**	**AMOUNT[1]**
919	Reveal Essentials+ Neighborhood	Provides ortho and oblique imagery at a Neighborhood level. Deliverables include measurable oblique and ortho imagery at a neighborhood resolutions. Color balanced orthomosaic imagery is generated by a fully automated photogrammetric process and delivered digitally in various formats with the associated metadata. Applicable Terms and Conditions: Delivered Content Terms and Conditions of Use Product Parameters: *Leaf:* Leaf Off: Less than 30% leaf cover	$ 160.00	$ 144.00 (10% - Long Term Incentive Discount)	$ 132,336.00
249	Reveal Essentials+ Property	Provides high resolution ortho and oblique imagery at a Property level. Deliverables include measurable oblique and ortho imagery at a property resolutions. Color balanced orthomosaic imagery is generated by a fully automated photogrammetric process and delivered digitally in various formats with the associated metadata. Applicable Terms and Conditions: Delivered Content Terms and Conditions of Use Product Parameters: *Leaf:* Leaf Off: Less than 30% leaf cover	$ 400.00	$ 342.00 (14.5% - Long Term Incentive Discount)	$ 85,158.00
162,000	ChangeFinder - Change Detection; Digital Parcel File Provided	Existing building outlines from a specified older imagery source are updated and classified relative to the most-nadir single-frame orthogonal image in a specified, newer Pictometry imagery source. Pictometry delivers updated digital building outlines from the newer imagery source and their classification attributes in shapefile and geodatabase formats. Coverage includes only locations specified in a single, customer-provided digital parcel shapefile. Parcels in the specified locations must be generally contiguous. All Pictometry imagery to be used must be licensed or owned by the customer. Final invoiced amount will be adjusted for the actual quantity of records in the parcel file used for production. Use of older non-Pictometry-sourced building outline data requires acceptance in advance. Applicable Terms and Conditions: Delivered Content Terms and Conditions of Use Product Parameters: *Data Source – Base:* Pictometry Outlines *Data Source Year – Base:* 2024 *Data Source – Comparison:* Pictometry Imagery *Data Source Year – Comparison:* 2025 *Deck Identification:* Marked with a Point *Regional Status Report Requested:* *Modified Technical Specifications:* *Parameter Changes* Prior to commencement of production, Customer may make changes to these product parameters by providing Pictometry with written authorization (email being acceptable).	$ 0.35		$ 56,700.00
1	CONNECT Gov 100 Package	CONNECT Gov 100 Package provides Customer with access to and use of Pictometry Connect - CA - 100, Pictometry Connect View - CA, and CONNECT	$ 5,000.00		$ 5,000.00

		ImageService CA as described elsewhere in this Agreement. Applicable Terms and Conditions: Online Services General Terms and Conditions;Software License Agreement			
1	FutureView Adv Training	Full conference registration to advanced training designed to maximize deployment. Includes hotel room for up to three nights, event registration, and round-trip airfare up to $500. Customer will be provided with discount code to complete FutureView registration. (Air Travel Restrictions - 30 day advance purchase for airfare, per person round trip airfare at standard coach class rates through Pictometry's travel provider only.) Must be redeemed within three years of agreement execution date. Applicable Terms and Conditions: Order Form	$ 2,499.00		$ 2,499.00
1	ChangeFinder - Project Fee	This is a flat fee per project. One project set-up fee is required for each Change Detection, Change Detection and Building Outlines, or Building Outline line item in the order. Applicable Terms and Conditions: Order Form	$ 1,000.00		$ 1,000.00
1	Oblique Imagery Bundle w/One (1) Year of EFS Maint & Support	Includes digital copy of the Licensed Documentation for the License Software, two (2) End User Training Sessions, one (1) Advanced User Technical Training, one (1) Administration / IT Training Session, five (5) hours of telephone support, one copy of Pictometry Electronic Field Study (EFS) software, latest version, on the storage media specified herein, and access to download updated versions of the EFS Licensed Software for a period of one years from the initial date of shipment of the EFS software, along with a copy of the updated documentation. Applicable Terms and Conditions: Software License Agreement	$ 0.00		$ 0.00
1	RapidAccess - Disaster Response Program	RapidAccess - Disaster Response Program is an emergency response program offering flights after an emergency or disaster. Refer to the attached detailed description of the Disaster Response Program. Applicable Terms and Conditions: Order Form	$ 0.00		$ 0.00
1	Pictometry Connect - EarlyAccess	Pictometry Connect - EarlyAccess provides authorized users the ability to login and access the imagery, as specified elsewhere in this agreement, immediately following its preliminary processing and quality control checks and prior to its final processing. Early Access imagery will become available in CONNECT Explorer incrementally as it is processed and it will remain available until final, fully processed imagery is made available through other means. This offering requires an active Pictometry CONNECT account and the current purchase of access to an imagery product. Applicable Terms and Conditions: Online Services General Terms and Conditions	$ 10,000.00	$ 0.00 (100%)	$ 0.00
919	Reveal Orthomosaic - Combined	This product represents a single orthomosaic, combining tiles of multiple resolutions with the best-available resolution preferred Applicable Terms and Conditions: Delivered Content Terms and Conditions of Use Product Parameters: *Leaf:* Leaf Off: Less than 30% leaf cover	$ 0.00		$ 0.00
1	CONNECT ImageService CA	Connect Image Service - CA (Custom Access) provides access via a secure web mapping service to existing orthomosaics available within Customer's Connect account. This service allows use by Customer each	$ 2,000.00	$ 0.00 (100%)	$ 0.00

		calendar month of a total number of image request transactions equal to the product resulting from multiplying (a) the number of concurrent users authorized to use the Connect Image Service pursuant to this Agreement, by (b) 1500 (such product being the "Monthly Image Request Limit"). To the extent use of the Connect Image Service pursuant to this Agreement results in a total number of image request transactions in excess of the Monthly Image Request Limit, Pictometry may review the usage with Customer, increase the price for Customer's Connect Image Service with Customer's consent or, in Pictometry's discretion, suspend further access by Customer to the Connect Image Service. This offering is provided solely for internal use within Customer's organization. Customer must maintain an active paid Pictometry Connect account in order to utilize the Connect Image Service. Applicable Terms and Conditions: Online Services General Terms and Conditions			
1	Pictometry Connect View - CA	Pictometry Connect View - CA (Custom Access) provides visualization-only access to the Pictometry-hosted custom imagery libraries specified elsewhere in this Agreement via a web application or server based integration. Requires a customer-provided web application or server based application. With respect to imagery available through this product to third parties or the Public, Pictometry reserves the right to reduce the resolution of the imagery available. Term commences on date of activation. The quantity represents the number of years in the Connect term. Applicable Terms and Conditions: Web Visualization Offering Terms and Conditions Product Parameters: *Admin User Name:* Tami Little *Admin User Email:* tamilit@clackamas.us	$ 750.00	$ 0.00 (100%)	$ 0.00
1	Pictometry Connect - CA - 100	Pictometry Connect - CA - 100 (Custom Access) provides up to 100 concurrent authorized users the ability to login and access the Pictometry-hosted custom imagery libraries specified elsewhere in this Agreement via a web-based, server-based or desktop integration. The default deployment is through web-based Pictometry Connect. Term commences on date of activation. The quantity represents the number of years in the Connect term. Applicable Terms and Conditions: Online Services General Terms and Conditions;Software License Agreement Product Parameters: *Admin User Name:* Tami Little *Admin User Email:* tamilit@clackamas.us	$ 3,300.00	$ 0.00 (100%)	$ 0.00
				SUBTOTAL	$282,693.00

SIXTH PROJECT

QTY	PRODUCT NAME	PRODUCT DESCRIPTION	LIST PRICE	DISCOUNT PRICE (%)	AMOUNT[1]
919	Reveal Essentials+ Neighborhood	Provides ortho and oblique imagery at a Neighborhood level. Deliverables include measurable oblique and ortho imagery at a neighborhood resolutions. Color balanced orthomosaic imagery is generated by a fully automated photogrammetric process and delivered digitally in various formats with the associated metadata. Applicable Terms and Conditions: Delivered Content Terms and Conditions of Use Product Parameters: *Leaf:* Leaf Off: Less than 30% leaf cover	$ 160.00	$ 144.00 (10% - Long Term Incentive Discount)	$ 132,336.00

249	Reveal Essentials+ Property	Provides high resolution ortho and oblique imagery at a Property level. Deliverables include measurable oblique and ortho imagery at a property resolutions. Color balanced orthomosaic imagery is generated by a fully automated photogrammetric process and delivered digitally in various formats with the associated metadata. Applicable Terms and Conditions: Delivered Content Terms and Conditions of Use Product Parameters: *Leaf:* Leaf Off: Less than 30% leaf cover	$ 400.00	$ 342.00 (14.5% - Long Term Incentive Discount)	$ 85,158.00
162,000	ChangeFinder - Change Detection; Digital Parcel File Provided	Existing building outlines from a specified older imagery source are updated and classified relative to the most-nadir single-frame orthogonal image in a specified, newer Pictometry imagery source. Pictometry delivers updated digital building outlines from the newer imagery source and their classification attributes in shapefile and geodatabase formats. Coverage includes only locations specified in a single, customer-provided digital parcel shapefile. Parcels in the specified locations must be generally contiguous. All Pictometry imagery to be used must be licensed or owned by the customer. Final invoiced amount will be adjusted for the actual quantity of records in the parcel file used for production. Use of older non-Pictometry-sourced building outline data requires acceptance in advance. Applicable Terms and Conditions: Delivered Content Terms and Conditions of Use Product Parameters: *Data Source – Base:* Pictometry Outlines *Data Source Year – Base:* 2025 *Data Source – Comparison:* Pictometry Imagery *Data Source Year – Comparison:* 2026 *Deck Identification:* Marked with a Point *Regional Status Report Requested:* *Modified Technical Specifications:* *Parameter Changes* Prior to commencement of production, Customer may make changes to these product parameters by providing Pictometry with written authorization (email being acceptable).	$ 0.35		$ 56,700.00
1	CONNECT Gov 100 Package	CONNECT Gov 100 Package provides Customer with access to and use of Pictometry Connect - CA - 100, Pictometry Connect View - CA, and CONNECT ImageService CA as described elsewhere in this Agreement. Applicable Terms and Conditions: Online Services General Terms and Conditions;Software License Agreement	$ 5,000.00		$ 5,000.00
1	FutureView Adv Training	Full conference registration to advanced training designed to maximize deployment. Includes hotel room for up to three nights, event registration, and round-trip airfare up to $500. Customer will be provided with discount code to complete FutureView registration. (Air Travel Restrictions - 30 day advance purchase for airfare, per person round trip airfare at standard coach class rates through Pictometry's travel provider only.) Must be redeemed within three years of agreement execution date. Applicable Terms and Conditions: Order Form	$ 2,499.00		$ 2,499.00

1	ChangeFinder - Project Fee	This is a flat fee per project. One project set-up fee is required for each Change Detection, Change Detection and Building Outlines, or Building Outline line item in the order. Applicable Terms and Conditions: Order Form	$ 1,000.00		$ 1,000.00
1	Pictometry Connect - EarlyAccess	Pictometry Connect - EarlyAccess provides authorized users the ability to login and access the imagery, as specified elsewhere in this agreement, immediately following its preliminary processing and quality control checks and prior to its final processing. Early Access imagery will become available in CONNECT Explorer incrementally as it is processed and it will remain available until final, fully processed imagery is made available through other means. This offering requires an active Pictometry CONNECT account and the current purchase of access to an imagery product. Applicable Terms and Conditions: Online Services General Terms and Conditions	$ 10,000.00	$ 0.00 (100%)	$ 0.00
1	CONNECT ImageService CA	Connect Image Service - CA (Custom Access) provides access via a secure web mapping service to existing orthomosaics available within Customer's Connect account. This service allows use by Customer each calendar month of a total number of image request transactions equal to the product resulting from multiplying (a) the number of concurrent users authorized to use the Connect Image Service pursuant to this Agreement, by (b) 1500 (such product being the "Monthly Image Request Limit"). To the extent use of the Connect Image Service pursuant to this Agreement results in a total number of image request transactions in excess of the Monthly Image Request Limit, Pictometry may review the usage with Customer, increase the price for Customer's Connect Image Service with Customer's consent or, in Pictometry's discretion, suspend further access by Customer to the Connect Image Service. This offering is provided solely for internal use within Customer's organization. Customer must maintain an active paid Pictometry Connect account in order to utilize the Connect Image Service. Applicable Terms and Conditions: Online Services General Terms and Conditions	$ 2,000.00	$ 0.00 (100%)	$ 0.00
1	Pictometry Connect View - CA	Pictometry Connect View - CA (Custom Access) provides visualization-only access to the Pictometry-hosted custom imagery libraries specified elsewhere in this Agreement via a web application or server based integration. Requires a customer-provided web application or server based application. With respect to imagery available through this product to third parties or the Public, Pictometry reserves the right to reduce the resolution of the imagery available. Term commences on date of activation. The quantity represents the number of years in the Connect term. Applicable Terms and Conditions: Web Visualization Offering Terms and Conditions Product Parameters: *Admin User Name:* Tami Little *Admin User Email:* tamilit@clackamas.us	$ 750.00	$ 0.00 (100%)	$ 0.00
1	Pictometry Connect - CA - 100	Pictometry Connect - CA - 100 (Custom Access) provides up to 100 concurrent authorized users the ability to login and access the Pictometry-hosted custom imagery libraries specified elsewhere in this Agreement via a web-based, server-based or desktop integration. The default deployment is through web-based Pictometry Connect. Term commences on date of activation. The quantity represents the number of years in the Connect term.	$ 3,300.00	$ 0.00 (100%)	$ 0.00

		Applicable Terms and Conditions: Online Services General Terms and Conditions;Software License Agreement Product Parameters: *Admin User Name:* Tami Little *Admin User Email:* tamilit@clackamas.us			
919	Reveal Orthomosaic - Combined	This product represents a single orthomosaic, combining tiles of multiple resolutions with the best-available resolution preferred Applicable Terms and Conditions: Delivered Content Terms and Conditions of Use Product Parameters: *Leaf:* Leaf Off: Less than 30% leaf cover	$ 0.00		$ 0.00
1	Oblique Imagery Bundle w/One (1) Year of EFS Maint & Support	Includes digital copy of the Licensed Documentation for the License Software, two (2) End User Training Sessions, one (1) Advanced User Technical Training, one (1) Administration / IT Training Session, five (5) hours of telephone support, one copy of Pictometry Electronic Field Study (EFS) software, latest version, on the storage media specified herein, and access to download updated versions of the EFS Licensed Software for a period of one years from the initial date of shipment of the EFS software, along with a copy of the updated documentation. Applicable Terms and Conditions: Software License Agreement	$ 0.00		$ 0.00
1	RapidAccess - Disaster Response Program	RapidAccess - Disaster Response Program is an emergency response program offering flights after an emergency or disaster. Refer to the attached detailed description of the Disaster Response Program. Applicable Terms and Conditions: Order Form	$ 0.00		$ 0.00
				SUBTOTAL	$282,693.00

SEVENTH PROJECT

QTY	PRODUCT NAME	PRODUCT DESCRIPTION	LIST PRICE	DISCOUNT PRICE (%)	AMOUNT[1]
919	Reveal Essentials+ Neighborhood	Provides ortho and oblique imagery at a Neighborhood level. Deliverables include measurable oblique and ortho imagery at a neighborhood resolutions. Color balanced orthomosaic imagery is generated by a fully automated photogrammetric process and delivered digitally in various formats with the associated metadata. Applicable Terms and Conditions: Delivered Content Terms and Conditions of Use Product Parameters: *Leaf:* Leaf Off: Less than 30% leaf cover	$ 160.00	$ 144.00 (10% - Long Term Incentive Discount)	$ 132,336.00
249	Reveal Essentials+ Property	Provides high resolution ortho and oblique imagery at a Property level. Deliverables include measurable oblique and ortho imagery at a property resolutions. Color balanced orthomosaic imagery is generated by a fully automated photogrammetric process and delivered digitally in various formats with the associated metadata. Applicable Terms and Conditions: Delivered Content Terms and Conditions of Use Product Parameters: *Leaf:* Leaf Off: Less than 30% leaf cover	$ 400.00	$ 342.00 (14.5% - Long Term Incentive Discount)	$ 85,158.00

162,000	ChangeFinder - Change Detection; Digital Parcel File Provided	Existing building outlines from a specified older imagery source are updated and classified relative to the most-nadir single-frame orthogonal image in a specified, newer Pictometry imagery source. Pictometry delivers updated digital building outlines from the newer imagery source and their classification attributes in shapefile and geodatabase formats. Coverage includes only locations specified in a single, customer-provided digital parcel shapefile. Parcels in the specified locations must be generally contiguous. All Pictometry imagery to be used must be licensed or owned by the customer. Final invoiced amount will be adjusted for the actual quantity of records in the parcel file used for production. Use of older non-Pictometry-sourced building outline data requires acceptance in advance. Applicable Terms and Conditions: Delivered Content Terms and Conditions of Use Product Parameters: *Data Source – Base:* Pictometry Outlines *Data Source Year – Base:* 2026 *Data Source – Comparison:* Pictometry Imagery *Data Source Year – Comparison:* 2027 *Deck Identification:* Marked with a Point *Regional Status Report Requested:* *Modified Technical Specifications:* *Parameter Changes* Prior to commencement of production, Customer may make changes to these product parameters by providing Pictometry with written authorization (email being acceptable).	$ 0.35		$ 56,700.00
1	CONNECT Gov 100 Package	CONNECT Gov 100 Package provides Customer with access to and use of Pictometry Connect - CA - 100, Pictometry Connect View - CA, and CONNECT ImageService CA as described elsewhere in this Agreement. Applicable Terms and Conditions: Online Services General Terms and Conditions;Software License Agreement	$ 5,000.00		$ 5,000.00
1	FutureView Adv Training	Full conference registration to advanced training designed to maximize deployment. Includes hotel room for up to three nights, event registration, and round-trip airfare up to $500. Customer will be provided with discount code to complete FutureView registration. (Air Travel Restrictions - 30 day advance purchase for airfare, per person round trip airfare at standard coach class rates through Pictometry's travel provider only.) Must be redeemed within three years of agreement execution date. Applicable Terms and Conditions: Order Form	$ 2,499.00		$ 2,499.00
1	ChangeFinder - Project Fee	This is a flat fee per project. One project set-up fee is required for each Change Detection, Change Detection and Building Outlines, or Building Outline line item in the order. Applicable Terms and Conditions: Order Form	$ 1,000.00		$ 1,000.00
1	Pictometry Connect - EarlyAccess	Pictometry Connect - EarlyAccess provides authorized users the ability to login and access the imagery, as specified elsewhere in this agreement, immediately following its preliminary processing and quality control checks and prior to its final processing. Early Access imagery will become available in CONNECT Explorer	$ 10,000.00	$ 0.00 (100%)	$ 0.00

		incrementally as it is processed and it will remain available until final, fully processed imagery is made available through other means. This offering requires an active Pictometry CONNECT account and the current purchase of access to an imagery product. Applicable Terms and Conditions: Online Services General Terms and Conditions			
1	RapidAccess - Disaster Response Program	RapidAccess - Disaster Response Program is an emergency response program offering flights after an emergency or disaster. Refer to the attached detailed description of the Disaster Response Program. Applicable Terms and Conditions: Order Form	$ 0.00		$ 0.00
1	Oblique Imagery Bundle w/One (1) Year of EFS Maint & Support	Includes digital copy of the Licensed Documentation for the License Software, two (2) End User Training Sessions, one (1) Advanced User Technical Training, one (1) Administration / IT Training Session, five (5) hours of telephone support, one copy of Pictometry Electronic Field Study (EFS) software, latest version, on the storage media specified herein, and access to download updated versions of the EFS Licensed Software for a period of one years from the initial date of shipment of the EFS software, along with a copy of the updated documentation. Applicable Terms and Conditions: Software License Agreement	$ 0.00		$ 0.00
919	Reveal Orthomosaic - Combined	This product represents a single orthomosaic, combining tiles of multiple resolutions with the best-available resolution preferred Applicable Terms and Conditions: Delivered Content Terms and Conditions of Use Product Parameters: *Leaf:* Leaf Off: Less than 30% leaf cover	$ 0.00		$ 0.00
1	Pictometry Connect - CA - 100	Pictometry Connect - CA - 100 (Custom Access) provides up to 100 concurrent authorized users the ability to login and access the Pictometry-hosted custom imagery libraries specified elsewhere in this Agreement via a web-based, server-based or desktop integration. The default deployment is through web-based Pictometry Connect. Term commences on date of activation. The quantity represents the number of years in the Connect term. Applicable Terms and Conditions: Online Services General Terms and Conditions;Software License Agreement Product Parameters: *Admin User Name:* Tami Little *Admin User Email:* tamilit@clackamas.us	$ 3,300.00	$ 0.00 (100%)	$ 0.00
1	CONNECT ImageService CA	Connect Image Service - CA (Custom Access) provides access via a secure web mapping service to existing orthomosaics available within Customer's Connect account. This service allows use by Customer each calendar month of a total number of image request transactions equal to the product resulting from multiplying (a) the number of concurrent users authorized to use the Connect Image Service pursuant to this Agreement, by (b) 1500 (such product being the "Monthly Image Request Limit"). To the extent use of the Connect Image Service pursuant to this Agreement results in a total number of image request transactions in excess of the Monthly Image Request Limit, Pictometry may review the usage with Customer, increase the price for Customer's Connect Image Service with Customer's consent or, in Pictometry's discretion, suspend further access by Customer to the Connect Image Service. This offering is provided solely for internal use within Customer's organization. Customer	$ 2,000.00	$ 0.00 (100%)	$ 0.00

		must maintain an active paid Pictometry Connect account in order to utilize the Connect Image Service. Applicable Terms and Conditions: Online Services General Terms and Conditions			
1	Pictometry Connect View - CA	Pictometry Connect View - CA (Custom Access) provides visualization-only access to the Pictometry-hosted custom imagery libraries specified elsewhere in this Agreement via a web application or server based integration. Requires a customer-provided web application or server based application. With respect to imagery available through this product to third parties or the Public, Pictometry reserves the right to reduce the resolution of the imagery available. Term commences on date of activation. The quantity represents the number of years in the Connect term. Applicable Terms and Conditions: Web Visualization Offering Terms and Conditions Product Parameters: *Admin User Name:* Tami Little *Admin User Email:* tamilit@clackamas.us	$ 750.00	$ 0.00 (100%)	$ 0.00
				SUBTOTAL	$282,693.00

[1]Amount per product = ((1-Discount %) * Qty * List Price)

STANDARD ORTHO MOSAIC PRODUCTS

Pictometry standard ortho mosaic products are produced through automated mosaicking processes that incorporate digital elevation data with individual Pictometry ortho frames to create large-area mosaics on an extremely cost-effective basis. Because these products are produced through automated processes, rather than more expensive manual review and hand-touched corrective processes, there may be inherent artifacts in some of the resulting mosaics. While Pictometry works to minimize such artifacts, the Pictometry standard ortho mosaic products are provided on an 'AS IS' basis with respect to visible cutlines along mosaic seams resulting from the following types of artifacts:

i. Disconnects in non-elevated surfaces generally caused by inaccurate elevation data;
ii. Disconnects in elevated surfaces (e.g., roadways, bridges, etc.) generally caused by elevated surfaces not being represented in the elevation data;
iii. Building intersect and clipping generally caused by buildings not being represented in the elevation data;
iv. Seasonal variations caused by images taken at different times during a season, or during different seasons;
v. Ground illumination variations caused by images taken under different illumination (e.g., sunny, high overcast, morning light, afternoon light, etc.) within one flight day or during different flight days;
vi. Single GSD color variations caused by illumination differences or multiple-aircraft/camera captures;
vii. Mixed GSD color variations caused by adjacent areas being flown at different ground sample distances (GSDs); and
viii. Water body color variations caused by multiple individual frames being used to create a mosaic across a body of water (e.g., lakes, ponds, rivers, etc.).

Other Pictometry products may be available that are less prone to such artifacts than the Pictometry standard ortho mosaic products.

Geofences:

SECOND PROJECT

For the Pictometry Connect - CA - 100, Pictometry Connect View - CA, CONNECT ImageService CA product(s) in this project, the following geofences apply:

OR Clackamas (Primary), OR State

THIRD PROJECT

For the Pictometry Connect - CA - 100, Pictometry Connect View - CA, CONNECT ImageService CA product(s) in this project, the following geofences apply:

OR Clackamas (Primary), OR State

FOURTH PROJECT

For the Pictometry Connect - CA - 100, Pictometry Connect View - CA, CONNECT ImageService CA product(s) in this project, the following geofences apply:

OR Clackamas (Primary), OR State

FIFTH PROJECT

For the Pictometry Connect - CA - 100, Pictometry Connect View - CA, CONNECT ImageService CA product(s) in this project, the following geofences apply:

OR Clackamas (Primary), OR State

SIXTH PROJECT
For the Pictometry Connect - CA - 100, Pictometry Connect View - CA, CONNECT ImageService CA product(s) in this project, the following geofences apply:
OR Clackamas (Primary), OR State

SEVENTH PROJECT
For the Pictometry Connect - CA - 100, Pictometry Connect View - CA, CONNECT ImageService CA product(s) in this project, the following geofences apply:
OR Clackamas (Primary), OR State

RapidAccess—Disaster Response Program ("DRP")
Customer is eligible for DRP described below from the Effective Date through the second anniversary of the initial Project delivery. Following payment to Pictometry of amounts due with respect to each subsequent Project, Customer will be eligible for the then-current DRP for a period of two years from delivery of such subsequent Project. Customer must be in good-standing with Pictometry to maintain eligibility for DRP.

A. **Disaster Coverage Imagery at No Additional Charge** – Pictometry will, upon request of Customer and at no additional charge, provide standard quality imagery of up to 200 square miles of affected areas (as determined by Pictometry) upon the occurrence of any of the following events during any period Customer is eligible for DRP:

- **Hurricane:** areas affected by hurricanes of Category 2 and higher.
- **Tornado:** areas affected by tornados rated EF4 and higher.
- **Terrorist:** areas affected by damage from terrorist attack.
- **Earthquake:** areas affected by damage to critical infrastructure resulting from earthquakes measured at 6.0 or higher on the Richter scale.
- **Tsunami:** areas affected by damage to critical infrastructure resulting from tsunamis.

B. **Discounted Rate** – Coverage for areas affected by the events set forth above exceeding 200 square miles will be, subject to Pictometry resource availability, offered to Customer at the then current DRP rates. Also, coverage for areas affected by hurricanes below Category II, tornadoes below EF4 or earthquakes rated below 6.0 on the Richter scale will be, subject to Pictometry resource availability, offered to Customer at the then current DRP rates.

C. **Online Services – Use of Pictometry Connect Explorer™** – Pictometry's DRP includes the use of Connect Explorer for a term of ninety days from the date of delivery of the DRP imagery. Customer shall have access to the DRP imagery for as long as they maintain an active Connect account.

FEES; PAYMENT TERMS

All amounts due to Pictometry pursuant to this Agreement ("Fees") are expressed in United States dollars and do not include any duties, taxes (including, without limitation, any sales, use, ad valorem or withholding, value added or other taxes) or handling fees, all of which are in addition to the amounts shown above and, to the extent applicable to purchases by Customer, shall be paid by Customer to Pictometry without reducing any amount owed to Pictometry unless documents satisfactory to Pictometry evidencing exemption from such taxes is provided to Pictometry prior to billing. To the extent any amounts properly invoiced pursuant to this Agreement are not paid within thirty (30) days following the invoice due date, such unpaid amounts shall accrue, and Customer shall pay, interest at the rate of 1.5% per month (or at the maximum rate allowed by law, if less). In addition, Customer shall pay Pictometry all costs Pictometry incurs in collecting past due amounts due under this Agreement including, but not limited to, attorneys' fees and court costs.

SECOND PROJECT

Due at Initial Shipment of Imagery	$282,693.00
Total Payments	**$282,693.00**

THIRD PROJECT

Due at Initial Shipment of Imagery	$282,693.00
Total Payments	**$282,693.00**

FOURTH PROJECT

Due at Initial Shipment of Imagery	$282,693.00
Total Payments	**$282,693.00**

FIFTH PROJECT

Due at Initial Shipment of Imagery	$282,693.00
Total Payments	**$282,693.00**

SIXTH PROJECT

Due at Initial Shipment of Imagery	$282,693.00
Total Payments	**$282,693.00**

SEVENTH PROJECT

Due at Initial Shipment of Imagery	$282,693.00
Total Payments	**$282,693.00**

Essentials+ Neighborhood deliverables

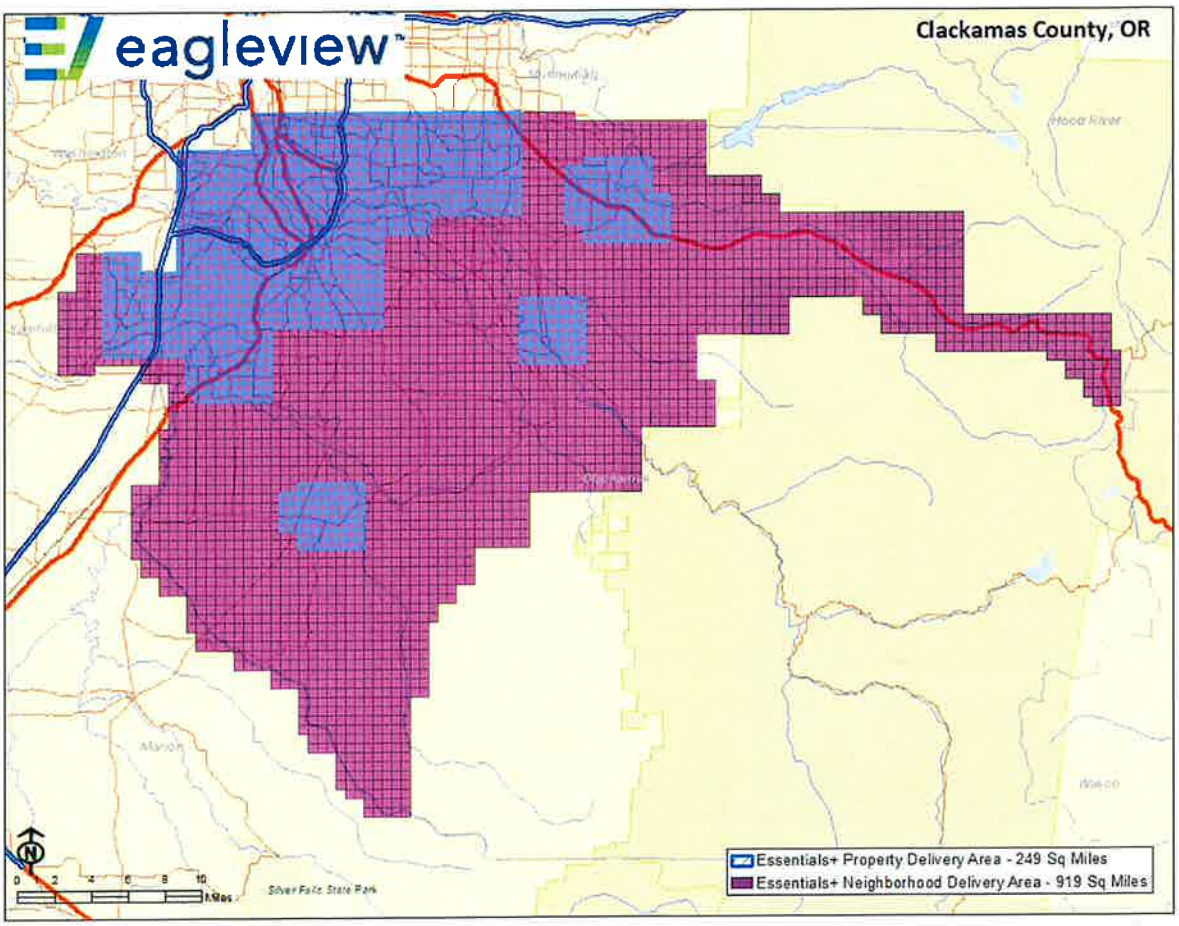
Product	Essentials+ Neighborhood
Orthomosaic Specifications	• Typical Positional Horizontal Accuracy: 1m at a 95% confidence level • Fully automated photogrammetric orthomosaic. Imagery may contain seamlines • Project-wide color and contrast balancing
Oblique Imagery	Nominal 6in GSD oblique imagery or better: • Where available fully automated photogrammetric mosaiced imagery. Imagery may contain seamlines
Metadata and Reporting	Metadata: • Metadata generated that meets FGDC Standards upon request • Shapefile(s) with discrete deliverable boundaries and directional metadata
Orthomosaic Deliverable Format (Online)	Resolution: • Nominal 6in GSD Access Methods: • Available via web-based viewer (Connect) - Contracted separately • Also available via WMS/WMTS (Image Service) - Contracted separately
Orthomosaic Deliverable Format (Physical)	Resolution: • Nominal 6in GSD Projection/Coordinate System: • Customer Selectable Datum: • Customer Selectable File Format: • Mosaic Tiles o Available as JPEG, GeoTIFF, JPEG2000, PNG, ECW, MrSID (All versions) with world file o Includes separate Pictometry Map Image (PMI) trailer file • Project-Wide Mosaic o Available in ECW, MrSID (All versions) format
Oblique Imagery Deliverable Format	Access methods: • Available via web-based viewer (Connect) - Contracted separately
Delivery Timeline	• Best efforts to make ortho and oblique imagery available online and/or ready for physical delivery within 30 days of capture completion

Essentials+ Property deliverables

Product	Essentials+ Property
Ortho Frame Imagery	• Nominal 2in GSD ortho imagery, Imagery as good as 1.2in and no worse than 3in
Orthomosaic Specifications	• Typical Positional Horizontal Accuracy: 1m at a 95% confidence level • Fully automated photogrammetric orthomosaic. Imagery may contain seamlines • Project-wide color and contrast balancing
Oblique Imagery	Nominal 2.6in GSD oblique imagery ranging from 1.7in to 3.5in GSD: • Where available fully automated photogrammetric mosaiced imagery. Imagery may contain seamlines

Metadata and Reporting	Metadata: • Metadata generated that meets FGDC Standards upon request • Shapefile(s) with discrete deliverable boundaries and directional metadata
Orthomosaic Deliverable Format (Online)	Resolution: • Nominal 2in GSD, no worse than 3in (Best Available Provided) Access Methods: • Available via web-based viewer (Connect) - Contracted separately • Also available via WMS/WMTS (Image Service) - Contracted separately
Orthomosaic Deliverable Format (Physical)	Resolution: • Nominal 2in GSD, no worse than 3in (Best Available Provided) Projection/Coordinate System: • Customer Selectable Datum: • Customer Selectable File Format: • Mosaic Tiles o Available as JPEG, GeoTIFF, JPEG2000, PNG, ECW, MrSID (All versions) with world file o Includes separate Pictometry Map Image (PMI) trailer file • Project-Wide Mosaic o Available in ECW, MrSID (All versions) format
Oblique Imagery & Frame Imagery Deliverable Format	Access methods: • Available via web-based viewer (Connect) - Contracted separately
Delivery Timeline	• Best efforts to make frame imagery available online within 20 days of capture complete • Best efforts to make ortho and oblique imagery available online and/or ready for physical delivery within 30 days of capture completion

MAP(S)


eagleview™
Clackamas County, OR
Hood River
Marion
Wasco
Silver Falls State Park
0 2 4 6 8 10
Miles
Essentials+ Property Delivery Area - 249 Sq Miles
Essentials+ Neighborhood Delivery Area - 919 Sq Miles

December 2, 2021

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of a Funding Agreement between
Clackamas County and Clackamas County Historical Society –
Museum of Oregon Territory

Purpose/Outcomes	Clackamas County is providing support to the Clackamas County Historical Society – Museum of Oregon Territory (CCHS) to provide solely operational support for the Museum of Oregon Territories.
Dollar Amount and Fiscal Impact	The agreement is for $100,000 total dollars.
Funding Source	General Fund dollars approved by the BCC in the 2021-22 budget cycle.
Duration	Becomes effective upon all signatures and ends on June 30, 2021
Strategic Plan Alignment	Honor, Utilize, Promote and Invest in our Natural Resources
Previous Board Action	No Previous Board Action
County Counsel Review	This Service Level Agreement has been reviewed and approved by A. Naylor on 11/22/21.
Procurement Review	No. Funding agreements are not reviewed by Procurement.
Contact Person	Nancy Bush x8893

BACKGROUND:
The Museum of the Oregon Territory (MOOT) is a regional benefit that overlooks Willamette Falls. The MOOT provides the history behind the land and how the Willamette Falls transformed the region's industry and is the home to Native American petroglyphs and artifacts, the original 1850 and 1851 San Francisco plat maps, a piece of the Willamette Meteorite, original belongings of Clackamas County's earliest re-settlers, as well as thousands of other objects, photographs, and documents that reflect Clackamas County history and culture.

MOOT will support the Board of County Commissioners in a proactive way enabling them to understand the various needs as well as the positive impact of historic preservation and culture in the county.

RECOMMENDATION:
Staff respectfully recommends approval of the Funding Agreement between Clackamas County and the Clackamas County Historic Society – Museum of Oregon Territory.

Sincerely,
Nancy Bush
Clackamas County Operations Officer

FUNDING AGREEMENT BETWEEN CLACKAMAS COUNTY AND CLACKAMAS COUNTY HISTORICAL SOCIETY – MUSEUM OF OREGON TERRITORY

THIS AGREEMENT (this "Agreement") is entered into and between **Clackamas County** ("County), a political subdivision of the State of Oregon, and Clackamas County Historical Society, doing business as the Museum of Oregon Territories (MOOT), an Oregon non-profit, collectively referred to as the "Parties" and each a "Party."

RECITALS

Clackamas County desires to provide MOOT funding to support operations at the MOOT, which was approved in the FY21/22 budget adopted by the Board of Commissioners on June 17, 2021.

In consideration of the mutual promises set forth below and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereby agree as follows:

TERMS

1. **Term.** This Agreement shall be effective upon execution, and shall expire June 30, 2022.
2. **Scope of Work and Consideration.** County agrees to award MOOT a grant in an amount not to exceed $100,000.00. MOOT shall use the funds awarded under this grant solely for the operation of the Museum of Oregon Territories, as further described in Exhibit A.
3. **Payment.** County will grant funds in two payments. Following execution of this Agreement, and within thirty (30) days following receipt of a written letter requesting disbursement, County will disburse the first payment of $50,000.00. On or after January 21, 2022, and within thirty (30) days following receipt of a written letter requesting disbursement, County will disburse the second payment of $50,000.00.
4. **Representations and Warranties.**

   A. *MOOT Representations and Warranties*: MOOT represents and warrants to County that MOOT has the power and authority to enter into and perform this Agreement, and this Agreement, when executed and delivered, shall be a valid and binding obligation of MOOT enforceable in accordance with its terms.

   B. *County Representations and Warranties*: County represents and warrants to MOOT that County has the power and authority to enter into and perform this Agreement, and this Agreement, when executed and delivered, shall be a valid and binding obligation of County enforceable in accordance with its terms.

   C. The warranties set forth in this section are in addition to, and not in lieu of, any other warranties provided.

5. **Termination.**

   A. Termination for Convenience. Either the County or MOOT may terminate this Agreement at any time prior to County distributing funds to MOOT. After County has distributed funds to MOOT, either Party may terminate this Agreement upon 120 days written notice to the other Party. In the event a party terminates this agreement under this Section 5 A,

MOOTshall immediately return all unspent funds to the County.

B. Termination for Breach. Either the County or MOOT may terminate this Agreement in the event of a breach of the Agreement by the other Party. Prior to such termination however, the party seeking the termination shall give the other Party written notice of the breach and of the Party's intent to terminate. If the breaching Party has not entirely cured the breach within fifteen (15) days of deemed or actual receipt of the notice, then the Party giving notice may terminate the Agreement at any time thereafter by giving written notice of termination stating the effective date of the termination. If the default is of such a nature that it cannot be completely remedied within such fifteen (15) day period, this provision shall be complied with if the breaching Party begins correction of the default within the fifteen (15) day period and thereafter proceeds with reasonable diligence and in good faith to effect the remedy as soon as practicable. The Party giving notice shall not be required to give more than one (1) notice for a similar default in any twelve (12) month period. Upon termination for breach, the terminating Party shall have all remedies available to it at law, in equity, or under this Agreement including, but not limited to, requiring MOOT to return all unspent funds and to repay County for any funds used by MOOT in violation of this Agreement.

C. Termination for Non-appropriation/Change in Law. Either Party may terminate this Agreement in the event either Party fails to receive expenditure authority sufficient to allow the Party, in the exercise of its reasonable administrative discretion, to perform under this Agreement. Additionally, either Party may terminate this Agreement if federal or state laws, regulations or guidelines are modified or interpreted in such a way that performance under this Agreement is prohibited. In the event of termination under this Subsection C, MOOT shall immediately return all unspent funds to the County.

D. Waiver. The County or MOOT shall not be deemed to have waived any breach of this Agreement by the other party except by an express waiver in writing. An express written waiver as to one breach shall not be deemed a waiver of any other breach not expressly identified, even though the other breach is of the same nature as that waived.

E. Reservation of Remedies. The termination of this Agreement, regardless of cause, shall not prejudice any rights or obligations accrued to the Parties prior to termination. Each party shall have all rights and remedies available to it at law, in equity, or under this Agreement.

6. **Indemnification**.

A. MOOT agrees to indemnify, hold harmless and defend County and its officers, elected officials, agents and employees from and against all claims and actions, and all expenses incidental to the investigation and defense thereof, arising out of or based upon damage or injuries to persons or property caused by the errors, omissions, fault or negligence of MOOT or MOOT's employees, subcontractors, or agents. However, neither MOOT nor any attorney engaged by MOOT shall defend the claim in the name of County or any department of County, nor purport to act as legal representative of County or any of its departments, without first receiving from the Clackamas County Counsel's Office authority to act as legal counsel for County, nor shall MOOT settle any claim on behalf of County without the approval of the Clackamas County Counsel's

Office. County may, at its election and expense, assume its own defense and settlement.

7. **Insurance.**
   - **A.** MOOT agrees to furnish the County with evidence of commercial general liability insurance with a combined single limit of not less than $1,000,000 for each claim, incident, or occurrence, with an aggregate limit of $2,000,000 for bodily injury and property damage. Such insurance shall name Clackamas County, and its officers, elected officials, agents, and employees as additional insureds.
   - **B.** MOOT agrees to provide statutory workers' compensation insurance coverage for all subject workers it employs, as defined in ORS 656.027, and in compliance with ORS 656.017, unless the workers meet the requirement for an exemption under ORS 656.126(2). MOOT agrees to furnish the County with evidence of this workers' compensation coverage.

8. **Notices; Contacts.** Legal notice provided under this Agreement shall be delivered personally, by email or by certified mail to the individuals identified below. Any communication or notice so addressed and mailed shall be deemed to be given upon receipt. Any communication or notice sent by electronic mail to an address indicated herein is deemed to be received 2 hours after the time sent (as recorded on the device from which the sender sent the email), unless the sender receives an automated message or other indication that the email has not been delivered. Any communication or notice by personal delivery shall be deemed to be given when actually delivered. Either Party may change the Party contact information, or the invoice or payment addresses by giving prior written notice thereof to the other Party at its then current notice address.

   A. Clackamas County Operations Officer, or their designee willact as liaison for the County.

   Nancy Bush
   2051 Kaen Road
   Oregon City, OR 97045
   nbush@clackamas.us | (503) 655-8893

   Executive Director or their designee will act as liaison for MOOT.

   Jenna Barganski
   Executive Director, Clackamas Historical Society
   PO Box 2211
   Oregon City, Oregon 97045
   director@clackamashistory.org | 503-655-5574

9. **General Provisions.**

   A. Oregon Law and Forum. This Agreement, and all rights, obligations, and disputes arising out of it will be governed by and construed in accordance with the laws of the State of Oregon and the ordinances of County and Clackamas County without giving effect to the conflict of law provisions thereof. Any claim between County and MOOT that arises from or relates to this Agreement shall be brought and conducted solely and exclusively within the Circuit Court of Clackamas County for the State of Oregon;

provided, however, if a claim must be brought in a federal forum, then it shall be brought and conducted solely and exclusively within the United States County Court for the County of Oregon. In no event shall this section be construed as a waiver by the County of any form of defense or immunity, whether sovereign immunity, governmental immunity, immunity based on the Eleventh Amendment to the Constitution of the United States or otherwise, from any claim or from the jurisdiction of any court. MOOT, by execution of this Agreement, hereby consents to the in jurisdiction of the courts referenced in this section.

B. **Compliance with Applicable Law**. Both Parties shall comply with all applicable local, state and federal ordinances, statutes, laws and regulations including, but not limited to, the requirement that use of the funds under this Agreement be used for purposes consistent with applicable law. All provisions of law requiredto be a part of this Agreement, whether listed or otherwise, are hereby integrated and adopted herein. Failure to comply with such obligations is a material breach of this Agreement.

C. **Non-Exclusive Rights and Remedies**. Except as otherwise expressly provided herein, the rights and remedies expressly afforded under the provisions of this Agreement shall not be deemed exclusive, and shall be in addition to and cumulative with any and all rights and remedies otherwise available at law or in equity. The exercise by either Party of any one or more of such remedies shall not preclude the exercise by it, at the same or different times, of any other remedies for the same default or breach, or for any other default or breach, by the other Party.

D. **Access to Records**. MOOT shall retain, maintain, and keep accessible all records relevant to this Agreement ("Records") for a minimum of six (6) years, following Agreement termination or full performance or any longer period as may be required by applicable law, or until the conclusion of an audit, controversy or litigation arising out of or related to this Agreement, whichever is later. MOOT shall maintain all financial recordsin accordance with generally accepted accounting principles. All other Records shall be maintained to the extent necessary to clearly reflect actions taken. During this record retention period, MOOT shall permit the County's authorized representatives' access to the Records at reasonable times and places for purposes of examining and copying.

E. **Reserved**.

F. **Debt Limitation.** This Agreement is expressly subject to the limitations of the Oregon Constitution and Oregon Tort Claims Act, and is contingent upon appropriation of funds. Any provisions herein that conflict with the above referenced laws are deemed inoperative to that extent.

G. **Severability.** If any provision of this Agreement is found to be unconstitutional, illegal or unenforceable, this Agreement nevertheless shall remain in full force and effect and the offending provision shall be stricken. The Court or other authorized body finding such provision unconstitutional, illegal or unenforceable shall construe this Agreement without such provision to give effect to the maximum extent possible the intentions of the Parties.

H. **Integration, Amendment and Waiver.** Except as otherwise set forth herein, this Agreement constitutes the entire agreement between the Parties on the matter of the Project. There are no understandings, agreements, or representations, oral or written,

not specified herein regarding this Agreement. No waiver, consent, modification or change of terms of this Agreement shall bind either Party unless in writing and signed by both Parties and all necessary approvals have been obtained. Such waiver, consent, modification or change, if made, shall be effective only in the specific instance and for the specific purpose given. The failure of either Party to enforce any provision of this Agreement shall not constitute a waiver by such Party of that or any other provision.

I. **Interpretation**. The titles of the sections of this Agreement are inserted for convenience of reference only and shall be disregarded in construing or interpreting any of its provisions.

J. **Independent Contractor**. Each of the Parties hereto shall be deemed an independent contractor for purposes of this Agreement. No representative, agent, employee or contractor of one Party shall be deemed to be a representative, agent, employee or contractor of the other Party for any purpose, except to the extent specifically provided herein. Nothing herein is intended, nor shall it be construed, to create between the Parties any relationship of principal and agent, partnership, joint venture or any similar relationship, and each Party hereby specifically disclaims any such relationship

K. **No Third-Party Beneficiary.** MOOT and County are the only parties to this Agreement and are the only parties entitled to enforce its terms. Nothing in this Agreement gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly, indirectly or otherwise, to third persons unless such third persons are individually identified by name herein and expressly described as intended beneficiaries of the terms of this Agreement.

L. **Subcontract and Assignment**. MOOT shall not enter into any subcontracts for any of the work required by this Agreement, or assign or transfer any of its interest in this Agreement by operation of law or otherwise, without obtaining prior written approval from the County, which shall be granted or denied in the County's sole discretion. County's consent to any subcontract shall not relieve MOOT of any of its duties or obligations under this Agreement.

M. **Counterparts**. This Agreement may be executed in several counterparts (electronic or otherwise), each of which shall be an original, all of which shall constitute the same instrument.

N. **Survival.** All provisions in Sections 4, 6, and 9 (A), (C), (D), (E), (F), (G), (H), (I), (J), (K), (N), (Q), (S), and (T) shall survive the termination of this Agreement, together with allother rights and obligations herein which by their context are intended to survive.

O. **Necessary Acts.** Each Party shall execute and deliver to the others all such further instruments and documents as may be reasonably necessary to carry out this Agreement.

P. **Reserved**.

Q. **Successors in Interest.** The provisions of this Agreement shall be binding upon and shall inure to the benefit of the parties hereto, and their respective authorized successors and assigns.

R. **Force Majeure.** Neither MOOT nor County shall be held responsible for delay or default caused by events outside of the MOOT or County's reasonable control including, but not limited to, fire, terrorism, riot, acts of God, or war. However, MOOT shall make all reasonable efforts to remove or eliminate such a cause of delay or default and shall upon the cessation of the cause, diligently pursue performance of its obligations under this Agreement.

S. **Confidentiality**. MOOT acknowledges that it and its employees or agents may, in the course of performing their responsibilities under this Agreement, be exposed to or acquire confidential information. Any and all information of any form obtained by MOOT or its employees or agents in the performance of this Agreement shall be deemed confidential information of the County ("Confidential Information"). MOOT agrees to hold Confidential Information in strict confidence, using at least the same degree of care that MOOT uses in maintaining the confidentiality of its own confidential information, and notto copy, reproduce, sell, assign, license, market, transfer or otherwise dispose of, give, or disclose Confidential Information to third parties or use Confidential Information for any purpose unless specifically authorized in writing under this Agreement.

T. **No Attorney Fees.** In the event any arbitration, action or proceeding, including any bankruptcy proceeding, is instituted to enforce any term of this Agreement, each party shall be responsible for its own attorneys' fees and expenses.

IN WITNESS HEREOF, the Parties have executed this Agreement by the date set forth opposite their names below.

Clackamas County

_____
Chair, Board of County Commissioners

Date _____

Clackamas County Historical Society

Jean Bangasser
Executive Director

Date 11/15/2021

County Counsel Approves to form

_____
County Counsel

Date 11/22/21

EXHIBIT A

SCOPE OF WORK

Background

The Clackamas County Historical Society – Museum of Oregon Territory (MOOT) is a regional museum that provides history behind the land and how Willamette Falls transformed the region's industry. MOOT is home to Native American petroglyphs and artifacts, the original 1850 Oregon City and 1851 San Francisco plat maps and other original belongings of Clackamas County's earliest settlers as well as documents that reflect Clackamas County history and culture.

Guiding Principles

This Agreement holds the following statements as guiding principles for Clackamas County Historic Society – Museum of Oregon Territory (MOOT) and Clackamas County (County):

- The historic preservation is important to our cultural and understanding of Clackamas County. MOOT provides education for all children and the general public.
- The unique cultural heritage and history of Clackamas County must be preserved and celebrated.
- The synergy that takes place when organizations and individuals share resources leads to a thriving arts and culture environment.

Use of Funds

MOOT shall use the $100,000.00 of General Fund budgeted in Clackamas County's FY 2021-22 Adopted Budget and granted under this Agreement for the following:

Clackamas County Historic Society – Museum of Oregon Territory (MOOT)

MOOT will use funds for operational expenses related to the operation of the Museum of Oregon Territory including, but not limited to, salaries; utility bills, educational program needs, needed repairs, etc.

MOOT will support the Board of County Commissioners in a proactive way enabling them to understand the various needs as well as the positive impact of historic preservation and culture in the county.

Monitoring. MOOT agrees to allow access to conduct financial and performance audits for the purpose of monitoring in accordance with Generally Accepted Auditing Standards ("GAAS"). County, and its duly authorized representatives, shall have access to such records and other books, documents, papers, plans, records of shipments and payments and writings of MOOT that are pertinent to this Agreement, whether in paper, electronic or other form, to perform examinations and audits and make excerpts, copies and transcripts. MOOT also agrees to provide reasonable access to MOOT's employees for the purpose of monitoring. Audits may be performed onsite or offsite, at the County's discretion. If any audit or financial review finds that payments to MOOT were in excess of the amount to which MOOT was entitled, then Moot shall repay that amount to County.

Financial Management. MOOT shall comply with Generally Accepted Accounting Principles (GAAP) or another equally accepted basis of accounting, use adequate internal controls, and maintain necessary sources documentation for all costs incurred.

Request for funding
Upon full signature of this agreement, MOOT must request the first $50,000 via a letter in order to process the disbursement. The second $50,000 must be requested no earlier than January 1, 2022 via a letter to the County Operations Officer.

Reporting
MOOT shall provide quarterly reports to the Clackamas County Operations Officer. Quarterly reports will include the following information:

- Reporting period
- How funds were spent
- If funding was used to support staff, provide name and position
- How did funding support the operations of MOOT for the quarter

Quarterly reports are due by:
September 30, 2021
December 31, 2021
March 31, 2022
June 30, 2022 – This quarterly report should be in the form of an annual report and presented to the Board of County Commissioners on an agreed date.

CLACKAMAS COUNTY COMMUNITY CORRECTIONS
1024 MAIN STREET • OREGON CITY • OREGON • 97045
TELEPHONE 503-655-8603 • • • FAX 503-650-8942

Capt. Malcolm McDonald
Director

Board of County Commissioners
Clackamas County

December 2, 2021

Members of the Board:

Approval of an Intergovernmental Agreement between
Clackamas County Community Corrections (CCCC) and Portland State University (PSU)

Purpose/Outcomes	Approval of an IGA between CCCC and PSU, for the development of phase one to create an assessment report that summarizes key priorities for an equity plan.
Dollar Amount and Fiscal Impact	$18,000 – No County General Funds are involved.
Funding Source(s)	Justice Reinvestment Grant funded by the State of Oregon Criminal Justice Commission (CJC)
Duration	Upon Execution – February 28, 2022
Previous Board Action	No Previous Board Action
Strategic Plan Alignment	1. Ensure safe, healthy and secure communities 2. Build public trust through good government
Counsel Review	This contract has been reviewed by County Counsel on November 16, 2021
Contact Person	Malcolm McDonald, CCCC Director (503) 655-8717
Contract Number	TBD

BACKGROUND: Clackamas County Local Public Safety Coordinating Council (LPSCC) has approached the PSU National Policy Consensus Center (NPCC), a nationally recognized leader in collaborative process, regarding the preparation of their Equity Plan. NPCC will help guide and support the LPSCC members and key partners that include: Clackamas County Equity, Diversity and Inclusion Council (EDIC); Clackamas County Leaders for Equity, Diversity and Inclusion Council (LEDIC), and the statewide Equity and Accountability Committee of the Justice Reinvestment Advisory Body, in phase one to create an assessment report that would summarize what interviewees identify as key priorities for an equity plan. NPCC would also provide LPSCC a scan of best practices that would be included in the final assessment report.

NPCC will produce the final report summarizing perspectives on the key priorities, issues, opportunities for shared activities, resources, data needs, and opportunities for community engagement (based on the assessment). Then facilitation of next steps for phase two will be planned for recommendations of the equity planning with Clackamas LPSCC.

RECOMMENDATION: CCCC respectfully requests that the Board of County Commissioners approve this Intergovernmental Agreement with PSU NPCC for the phase one development of an equity plan, and authorizes Malcolm McDonald, CCCC Director to sign on behalf of Clackamas County and Commissioner Tootie Smith, Chair, to sign on behalf of the Board of County Commissioners.

Respectfully submitted,

Captain Malcolm McDonald
Director, Community Corrections

INTERGOVERNMENTAL AGREEMENT
BETWEEN CLACKAMAS COUNTY
AND PORTLAND STATE UNIVERSITY

THIS AGREEMENT (this "Agreement") is entered into and between Clackamas County ("County"), a political subdivision of the State of Oregon, and Portland State University ("Agency"), corporation unit of local government as that term is defined under ORS 190.003, collectively referred to as the "Parties" and each a "Party."

RECITALS

Oregon Revised Statutes Chapter 190.010 confers authority upon local governments to enter into agreements for the performance of any and all functions and activities that a party to the agreement, its officers or agencies have authority to perform.

Clackamas County Local Public Safety Coordinating Council (LPSCC) has approached The National Policy Consensus Center (NPCC), a nationally recognized leader in collaborative process, regarding the preparation of their Equity Plan. NPCC will help guide and support the LPSCC members and key partners that include: Clackamas County Equity, Diversity and Inclusion Council (EDIC); Clackamas County Leaders for Equity, Diversity and Inclusion Council (LEDIC), and the statewide Equity and Accountability Committee of the Justice Reinvestment Advisory Body, in phase one to create an assessment report that would summarize what interviewees identify as key priorities for an equity plan. NPCC would also provide LPSCC a scan of best practices that would be included in the final assessment report.

In consideration of the mutual promises set forth below and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereby agree as follows:

TERMS

1. **Term.** This Agreement shall be effective upon execution, and shall expire upon the completion of each and every obligation of the Parties set forth herein, or February 28, 2022, whichever is sooner.
2. **Scope of Work.** The Agency agrees to provide the services further identified in the Scope of Work attached hereto as Exhibit A and incorporated herein ("Work").
3. **Consideration.** The County agrees to pay Agency, from available and authorized funds, a sum not to exceed **Eighteen Thousand Dollars** ($18,000) for accomplishing the Work required by this Agreement.
4. **Payment.** Unless otherwise specified, the Agency shall submit an initial invoice for 75% of contract amount by December 15, 2021. Agency will invoice for 25% of remaining balance of contract upon completion of work by February 28, 2022. Invoices shall describe all Work performed with particularity, by whom it was performed, and shall itemize and explain all expenses for which reimbursement is claimed. Payments shall be made to Agency following the County's review and approval of invoices submitted by Agency. Agency shall not submit invoices for, and the County will not pay, any amount in excess of the maximum compensation amount set forth above.
5. **Representations and Warranties**.
   A. *Agency Representations and Warranties*: Agency represents and warrants to County that Agency has the power and authority to enter into and perform this Agreement, and

this Agreement, when executed and delivered, shall be a valid and binding obligation of Agency enforceable in accordance with its terms.

B. *County Representations and Warranties*: County represents and warrants to Agency that County has the power and authority to enter into and perform this Agreement, and this Agreement, when executed and delivered, shall be a valid and binding obligation of County enforceable in accordance with its terms.

C. The warranties set forth in this section are in addition to, and not in lieu of, any other warranties provided.

6. **Termination**.

   A. Either the County or the Agency may terminate this Agreement at any time upon thirty (30) days written notice to the other party.

   B. Either the County or the Agency may terminate this Agreement in the event of a breach of the Agreement by the other. Prior to such termination however, the Party seeking the termination shall give the other Party written notice of the breach and of the Party's intent to terminate. If the breaching Party has not entirely cured the breach within fifteen (15) days of deemed or actual receipt of the notice, then the Party giving notice may terminate the Agreement at any time thereafter by giving written notice of termination stating the effective date of the termination. If the default is of such a nature that it cannot be completely remedied within such fifteen (15) day period, this provision shall be complied with if the breaching Party begins correction of the default within the fifteen (15) day period and thereafter proceeds with reasonable diligence and in good faith to effect the remedy as soon as practicable. The Party giving notice shall not be required to give more than one (1) notice for a similar default in any twelve (12) month period.

   C. The County or the Agency shall not be deemed to have waived any breach of this Agreement by the other Party except by an express waiver in writing. An express written waiver as to one breach shall not be deemed a waiver of any other breach not expressly identified, even though the other breach is of the same nature as that waived.

   D. The County may terminate this Agreement in the event the County fails to receive expenditure authority sufficient to allow the County, in the exercise of its reasonable administrative discretion, to continue to perform under this Agreement, or if federal or state laws, regulations or guidelines are modified or interpreted in such a way that either the Project under this Agreement is prohibited or the County is prohibited from paying for such work from the planned funding source.

   E. Any termination of this Agreement shall not prejudice any rights or obligations accrued to the Parties prior to termination.

7. **Indemnification**.

   A. Subject to the limits of the Oregon Constitution and the Oregon Tort Claims Act or successor statute, the County agrees to indemnify, save harmless and defend the Agency, its officers, elected officials, agents and employees from and against all costs, losses, damages, claims or actions and all expenses incidental to the investigation and defense thereof arising out of or based upon damages or injuries to persons or property caused by the negligent or willful acts of the County or its officers, elected officials, owners, employees, agents, or its subcontractors or anyone over which the County has a right to control.

   Subject to the limits of the Oregon Constitution and the Oregon Tort Claims Act or successor statute, the Agency agrees to indemnify, save harmless and defend the County, its officers, elected officials, agents and employees from and against all costs, losses, damages, claims or actions and all expenses incidental to the investigation and defense thereof arising out of or based upon damages or injuries to persons or property caused by the negligent or willful acts of the Agency or its officers, elected

officials, owners, employees, agents, or its subcontractors or anyone over which the Agency has a right to control.

8. **Insurance.** The Parties agree to maintain levels of insurance, or self-insurance, sufficient to satisfy their obligations under this Agreement and all requirements under applicable law.

9. **Notices; Contacts.** Legal notice provided under this Agreement shall be delivered personally, by email or by certified mail to the individuals identified below. Any communication or notice so addressed and mailed shall be deemed to be given upon receipt. Any communication or notice sent by electronic mail to an address indicated herein is deemed to be received 2 hours after the time sent (as recorded on the device from which the sender sent the email), unless the sender receives an automated message or other indication that the email has not been delivered. Any communication or notice by personal delivery shall be deemed to be given when actually delivered. Either Party may change the Party contact information, or the invoice or payment addresses by giving prior written notice thereof to the other Party at its then current notice address.

   A. Captain Malcolm McDonald or their designee will act as liaison for the County.

   Contact Information:

   Clackamas County Community Corrections
   Email: malcolmmcd@clackamas.us
   Phone: (503) 655-8717

   Laurel Singer or their designee will act as liaison for the Agency.

   Contact Information:

   National Policy Consensus Center
   Email: laurels@pdx.edu
   Phone: (503) 784-5904

10. **General Provisions.**

   A. **Oregon Law and Forum.** This Agreement, and all rights, obligations, and disputes arising out of it will be governed by and construed in accordance with the laws of the State of Oregon and the ordinances of Clackamas County without giving effect to the conflict of law provisions thereof. Any claim between County and Agency that arises from or relates to this Agreement shall be brought and conducted solely and exclusively within the Circuit Court of Clackamas County for the State of Oregon; provided, however, if a claim must be brought in a federal forum, then it shall be brought and conducted solely and exclusively within the United States District Court for the District of Oregon. In no event shall this section be construed as a waiver by the County of any form of defense or immunity, whether sovereign immunity, governmental immunity, immunity based on the Eleventh Amendment to the Constitution of the United States or otherwise, from any claim or from the jurisdiction of any court. Agency, by execution of this Agreement, hereby consents to the in personam jurisdiction of the courts referenced in this section.

B. **Compliance with Applicable Law**. Both Parties shall comply with all applicable local, state and federal ordinances, statutes, laws and regulations. All provisions of law required to be a part of this Agreement, whether listed or otherwise, are hereby integrated and adopted herein. Failure to comply with such obligations is a material breach of this Agreement.

C. **Non-Exclusive Rights and Remedies**. Except as otherwise expressly provided herein, the rights and remedies expressly afforded under the provisions of this Agreement shall not be deemed exclusive, and shall be in addition to and cumulative with any and all rights and remedies otherwise available at law or in equity. The exercise by either Party of any one or more of such remedies shall not preclude the exercise by it, at the same or different times, of any other remedies for the same default or breach, or for any other default or breach, by the other Party.

D. **Access to Records**. Agency shall retain, maintain, and keep accessible all records relevant to this Agreement ("Records") for a minimum of six (6) years, following Agreement termination or full performance or any longer period as may be required by applicable law, or until the conclusion of an audit, controversy or litigation arising out of or related to this Agreement, whichever is later. Agency shall maintain all financial records in accordance with generally accepted accounting principles. All other Records shall be maintained to the extent necessary to clearly reflect actions taken. During this record retention period, Agency shall permit the County's authorized representatives' access to the Records at reasonable times and places for purposes of examining and copying.

E. **Work Product.** All work performed under this Agreement shall be considered work made for hire and shall be the sole and exclusive property of the District. The District shall own any and all data, documents, plans, copyrights, specifications, working papers and any other materials produced in connection with this Agreement. On completion or termination of the Agreement, the Agency shall promptly deliver these materials to the District's Project Manager.

F. **Debt Limitation.** This Agreement is expressly subject to the limitations of the Oregon Constitution and Oregon Tort Claims Act, and is contingent upon appropriation of funds. Any provisions herein that conflict with the above referenced laws are deemed inoperative to that extent.

G. **Severability.** If any provision of this Agreement is found to be unconstitutional, illegal or unenforceable, this Agreement nevertheless shall remain in full force and effect and the offending provision shall be stricken. The Court or other authorized body finding such provision unconstitutional, illegal or unenforceable shall construe this Agreement without such provision to give effect to the maximum extent possible the intentions of the Parties.

H. **Integration, Amendment and Waiver.** Except as otherwise set forth herein, this Agreement constitutes the entire agreement between the Parties on the matter of the Project. There are no understandings, agreements, or representations, oral or written, not specified herein regarding this Agreement. No waiver, consent, modification or change of terms of this Agreement shall bind either Party unless in writing and signed

by both Parties and all necessary approvals have been obtained. Such waiver, consent, modification or change, if made, shall be effective only in the specific instance and for the specific purpose given. The failure of either Party to enforce any provision of this Agreement shall not constitute a waiver by such Party of that or any other provision.

I. **Interpretation**. The titles of the sections of this Agreement are inserted for convenience of reference only and shall be disregarded in construing or interpreting any of its provisions.

J. **Independent Contractor**. Each of the Parties hereto shall be deemed an independent contractor for purposes of this Agreement. No representative, agent, employee or contractor of one Party shall be deemed to be a representative, agent, employee or contractor of the other Party for any purpose, except to the extent specifically provided herein. Nothing herein is intended, nor shall it be construed, to create between the Parties any relationship of principal and agent, partnership, joint venture or any similar relationship, and each Party hereby specifically disclaims any such relationship.

K. **No Third-Party Beneficiary.** Agency and County are the only parties to this Agreement and are the only parties entitled to enforce its terms. Nothing in this Agreement gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly, indirectly or otherwise, to third persons unless such third persons are individually identified by name herein and expressly described as intended beneficiaries of the terms of this Agreement.

L. **Subcontract and Assignment**. Agency shall not enter into any subcontracts for any of the work required by this Agreement, or assign or transfer any of its interest in this Agreement by operation of law or otherwise, without obtaining prior written approval from the County, which shall be granted or denied in the County's sole discretion. County's consent to any subcontract shall not relieve Agency of any of its duties or obligations under this Agreement.

M. **Counterparts**. This Agreement may be executed in several counterparts (electronic or otherwise), each of which shall be an original, all of which shall constitute the same instrument.

N. **Survival.** All provisions in Sections 5, 7, and 10 (A), (C), (D), (E), (G), (H), (I), (J), (L), (O), (Q), (R), (T), and (U) shall survive the termination of this Agreement, together with all other rights and obligations herein which by their context are intended to survive.

O. **Necessary Acts.** Each Party shall execute and deliver to the others all such further instruments and documents as may be reasonably necessary to carry out this Agreement.

P. **Time is of the Essence**. Agency agrees that time is of the essence in the performance this Agreement.

Q. **Successors in Interest.** The provisions of this Agreement shall be binding upon and shall inure to the benefit of the parties hereto, and their respective authorized successors and assigns.

R. **Force Majeure.** Neither Agency nor County shall be held responsible for delay or default caused by events outside of the Agency or County's reasonable control including, but not limited to, fire, terrorism, riot, acts of God, or war. However, Agency shall make all reasonable efforts to remove or eliminate such a cause of delay or default and shall upon the cessation of the cause, diligently pursue performance of its obligations under this Agreement.

S. **Confidentiality**. Agency acknowledges that it and its employees or agents may, in the course of performing their responsibilities under this Agreement, be exposed to or acquire confidential information. Any and all information of any form obtained by Agency or its employees or agents in the performance of this Agreement shall be deemed confidential information of the County ("Confidential Information"). Agency agrees to hold Confidential Information in strict confidence, using at least the same degree of care that Agency uses in maintaining the confidentiality of its own confidential information, and not to copy, reproduce, sell, assign, license, market, transfer or otherwise dispose of, give, or disclose Confidential Information to third parties or use Confidential Information for any purpose unless specifically authorized in writing under this Agreement.

T. **No Attorney Fees.** In the event any arbitration, action or proceeding, including any bankruptcy proceeding, is instituted to enforce any term of this Agreement, each party shall be responsible for its own attorneys' fees and expenses.

IN WITNESS HEREOF, the Parties have executed this Agreement by the date set forth opposite their names below.

Clackamas County

Chair, Tootie Smith
Commissioner, Sonya Fischer
Commissioner, Paul Savas
Commissioner, Martha Schrader
Commissioner, Mark Shull

Signing on Behalf of Clackamas County Community Corrections

_____
Chair, Board of County Commissioners

_____
Date

Portland State University National Policy Consensus Center

Executive Director, Laurel Singer,
or authorized representative

Signing on Behalf of Portland State University National Policy Consensus Center

_____
Name: Laurel Singer
Title: Executive Director

_____
Date

Exhibit A
SCOPE OF WORK

The Project

Portland State University, through its National Policy Consensus Center (NPCC), will conduct an assessment, consisting of interviews with current Local Public Safety Coordinating Council LPSCC members and key partners, that could serve as a foundation for shared action in crafting and implementing an equity plan.

NPCC will create an assessment report that summarizes what interviewees identify as key priorities for an equity plan, issues that would be addressed in implementing an equity plan, ideas for public engagement, current efforts and resources within the LPSCC entities, existing and needed data, and recommendations for next steps. NPCC staff will also provide a scan of best practices that would be included in the final assessment report.

NPCC will work with LPSCC members and leadership to review this report and identify next steps and potential resources that would be available to create and implement an equity plan, which may involve some on-going work facilitated by NPCC.

Scope of Work: Assessment Activities

The following details the tasks associated with completing "phase 1" assessment activities:

- **Develop interview protocols.** These protocols would outline assessment questions, what and how to communicate with LPSCC members about the assessment, who to interview, contact information for interviewees, management of information. NPCC staff would work with the identified LPSCC leader(s) to finalize protocols and initiative communication about the assessment. (October)

- **Interview LPSCC chair and members** using questions developed. (Late October – November)

- **Interview other key community members, community based organization members and public officials** regarding the Clackamas criminal justice system and racial equity issues. This part of the scope would also explore how this effort intersects with exploring a) Clackamas County Equity, Diversity and Inclusion Council (EDIC), b) Clackamas County Leaders for Equity, Diversity and Inclusion Council (LEDIC), and c) the statewide Equity and Accountability Committee of the Justice Reinvestment Advisory Body and their September 2020 report. (Late October – November)

- **Conduct research scan about best practices** that may be utilized by LPSCC in addressing issues of equity. (November)

- **Synthesize and compile a report** the information gained through interviews and research scan (December)

- **Facilitate a meeting with LPSCC chair and members** to review the report and identify potential next steps. (February 2022)

Deliverables

- A final report summarizing perspectives on the key priorities, issues, opportunities for shared activities, resources, data needs, and opportunities for community engagement (based on the assessment) for discussion with the Clackamas LPSCC.

- Recommendations for next steps in the equity planning process.

- Facilitation of next steps discussion with the full LPSCC.

CLACKAMAS
WATER ENVIRONMENT SERVICES

Gregory L. Geist
Director

December 2, 2021

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of the Agreement between Water Environment Services and Portland General Electric Company for the First Supplement to Agreement for Primary Voltage Alternate Electric Services under Schedule 83. Fiscal Impact is $77,280 through WES Capital Improvement Funds. No General Fund dollars are involved.

Purpose/Outcome	Approval of the Agreement between Water Environment Services and Portland General Electric Company for the First Supplement to Agreement For Primary Voltage Alternate Electric Services Under Schedule 83.
Dollar Amount and Fiscal Impact	$77,280
Funding Source	WES Capital Improvement Funds. No general fund dollars.
Duration	The Agreement ends December 31, 2041.
Previous Board Action/Review	This item was presented at Issues on November 30, 2021. Construction of TC WRRF on May 10, 1988.
Strategic Plan Alignment	1. This project supports the WES Strategic Plan to provide Enterprise Resiliency, Infrastructure Strategy and Performance and Operational Optimization and support the expected 20-year growth horizon. 2. This project supports the County Strategic Plan to build public trust through good government and building strong infrastructure.
Counsel Review	Review Date: November 22, 2021 Counsel: Amanda Keller
Procurement Review	Was this project processed through Procurement? Yes ☐ No ☒ Item is a cooperative agreement with Portland General Electric.
Contact Person	Jeff Stallard, WES Capital Supervisor, 503-278-2311
Contract No.	NA

BACKGROUND:
WES is required to provide emergency backup power to the Tri City Water Resource Recovery Facility (TC WRRF) to keep the plant operational during unplanned power outages. During construction of the TC WRRF in the mid-1980's, it was determined that the preferred way to meet this requirement was to have a two power feeds to the plant from two different PGE Substations (Abernethy and Jennings). At that time, WES paid a lump sum amount to secure

reserve power from PGE on the secondary Jennings substation. In 2012, an on-site generator was added for back-up power for a portion of the facility, while the dual PGE feeds remained to power a portion.

With the completion of the Solids project, WES now has a need to secure additional reserve capacity (400kw) on the Jennings Substation to provide required emergency backup power. This contract will secure the required reserve capacity on the Jennings substation.

At this time, WES has elected to pay for his required additional capacity on a monthly basis ($322/month) in lieu of a lump sum fee ($60,032). This approach will provide WES with flexibility to provide this required emergency backup today, and avoid a stranded investment should future studies and expansions require a different approach.

RECOMMENDATION:
WES staff recommends the Board, acting as the governing body of Water Environment Services, approve the Agreement between Water Environment Services and Portland General Electric Company for the First Supplement to Agreement for Primary Voltage Alternate Electric Services under Schedule 83.

Respectfully submitted,

Greg Geist
Director, WES

Attachments: First Supplement to Agreement for Primary Voltage Alternate Electric Service under Schedule 83.

CLACKAMAS
WATER
ENVIRONMENT
SERVICES

RECORDING MEMO

☑ New Agreement/Contract

☐ Amendment/Change/Extension

☑ Other: _____

Originating County Department: Water Environment Services

Purchasing for: _____

Other party to contract/agreement: Portland General Electric

Title from Business Meeting Agenda:

Chair

After recording please return to:

Water Environment Services
c/o Lauren Haney, Administrative Services
150 Beavercreek Road, Suite 430
Oregon City, OR 97045

Clerk to the Board please complete below this line after Board approval

Board Agenda Date: _____

Agenda Item Number: _____

WATER ENVIRONMENT SERVICES AND

PORTLAND GENERAL ELECTRIC COMPANY

FIRST SUPPLEMENT TO AGREEMENT FOR PRIMARY VOLTAGE ALTERNATE ELECTRIC SERVICE UNDER SCHEDULE 83

Customer's Premises: 15941 S. Agnes Rd., Oregon City, OR 97045

NOVEMBER 19, 2021

This First Supplement to Agreement for Primary Voltage Alternate Electric Service Under Schedule 83 ("Supplement") is entered into by and between WATER ENVIRONMENT SERVICES ("Customer"), an intergovernmental entity formed pursuant to Oregon Revised Statutes Chapter 190, with its principal place of business at 15941 S. Agnes Rd., Oregon City, OR 97045, and PORTLAND GENERAL ELECTRIC COMPANY ("PGE"), an Oregon corporation with its principal place of business at 121 SW Salmon St., Portland, OR 97204. Hereafter, Customer and PGE may be referred to individually as a "Party" and collectively as "the Parties."

WHEREAS, PGE and Tri-City Service District previously entered into an Agreement for Primary Voltage Alternate Electric Service Under Schedule 83, dated May 10, 1988 (the "Existing Agreement"); and

WHEREAS, on or about July 17, 2017, Tri-City Service District assigned, transferred and set over unto Water Environment Services all of Tri-City Service District's rights, title, and interests in and to all its contracts, including the Existing Agreement, and Water Environment Services accepted such assignment, thereby agreeing to be bound by and to pay and perform, observe and discharge all of the duties under the Existing Agreement; all of which was accomplished in accordance with the agreement attached hereto as Exhibit A; and

WHEREAS, the Parties desire to supplement and, in the instances identified herein, supersede certain of the terms and conditions of the Existing Agreement for purposes of increasing the amount of "alternate kVA" capacity to be reserved under paragraph 5 of the Existing Agreement, for Customer's emergency use; and

WHEREAS, it is appropriate for the changes contemplated herein by the Parties to be documented in written form and executed by both Parties.

NOW, THEREFORE, in consideration of the mutual promises, considerations and representations set forth herein, the Parties agree as follows:

1. Term of Supplement
   a) This Supplement shall commence on the date on which the latter of the two Parties executes this agreement (the "Effective Date") and remain in effect for twenty (20) years, unless earlier terminated in accordance with Section 10 herein.

   b) Customer may renew this Supplement for an additional 10-year term by providing PGE written notice of its intent to renew at least 30 days prior to the end of the then-current term (each a "Renewal Term" and together with the Initial Term, the "Term"). If the Term is renewed for any Renewal Term(s) pursuant to this Section, the terms and conditions of this Supplement during each such Renewal Term shall be the same as the terms and conditions in effect immediately prior to such renewal. If Customer fails to provide timely notice of its intent to renew this Supplement, then, unless otherwise sooner terminated in accordance with its terms, this Supplement shall terminate on the expiration of the then-current Term.

2. Conditions of Service
   a) No Installation of Additional Equipment by Customer and No Additional Operating Conditions. No additional equipment must be installed by Customer and no additional operating conditions must be imposed in order for PGE to accommodate Customer's requested increase in its capacity reservation for Alternate Service under this Supplement.

   b) This Supplement provides for an increase in capacity only—up from the original 1200 kVA to 1600 kVA—but does not authorize any increase in alternate capacity or service above 1600 kVA. Service may, therefore, be interrupted if actual kVA demand on the existing alternate service facilities exceeds the aggregated maximum of 1600 kVA, (hereafter sometimes referred to as "the Total Contracted Amount") that is collectively reserved by Customer pursuant to paragraph 5 of the Existing Agreement (the initial 1200 kVA) and paragraph 3 of this Supplement (for the additional 400kW).

3. Additional Contracted Amount of Alternate Capacity

The additional amount of reserved capacity that PGE shall maintain for Customer's use, subject to the terms of this Supplement, is 400 kW.

4. Location to be Served and Designated Service Point

a) Pursuant to the terms of this Supplement, 400kW of Additional Alternate Service will be available to the same Location at that described in the Existing Agreement [15941 S. Agnes Rd, Oregon City, Oregon 97045].

b) The point of delivery for the Total Contracted Amount of Alternate Service available under both the Existing Agreement and this Supplement is described as: **The line side termination at the customer's primary voltage switchgear at the address listed in paragraph 2 of the Existing Agreement, more specifically, at Service Point ID # 0550222319.** To be clear, this paragraph 4.b. is intended to supersede the terms and conditions contained in paragraph 3 of the Existing Agreement, at least for the duration of this Supplement.

5. Payment

a) Customer agrees to make timely payments to PGE, in the amount of $322.00 per month, in exchange for no more than 400 kW of additional reserved capacity available to serve the location/Service Point noted above.

b) Customer shall, at all times, ensure that its demand for alternate electric service does not exceed the Total Contracted Amount of reserved capacity, and Customer shall promptly execute a supplemental or new agreement for any amount of alternate capacity above 1600 kVA that may be required.

c) If and when the alternate service capacity is utilized by Customer, then, in addition to the capacity reservation charge listed above, Customer's monthly billing will also consist of the standard kW and kVAR demand charges on either the preferred or alternate service feeder, whichever is the greater, the sum total kWh charge for both services and, in the event that Customer imposes a demand on the alternate service facilities in excess of the 1600 kVA contracted for, Customer will pay PGE an additional monthly amount for that month and the succeeding eleven (11) months. Such additional amount will be determined by multiplying the excess kVA demand by the current sum of tariffed transmission and distribution demand charges and the applicable facilities capacity charges. Should a condition of excess kVA demand occur, Customer shall promptly modify plant operation(s) to prevent further excess demand until a new or supplemental agreement, for an additional amount of reserved capacity (above 1600kVA) can be executed between the Parties. It is understood and agreed that the cost of additional reserved capacity will be based on the effective costs of such, to PGE, at that time. Finally, Customer will be billed and shall pay the actual cost of any damage to PGE's facilities that are caused by Customer's demand on the alternate service facilities in excess of the Total Contracted Amount of capacity. Customer shall also be subject to indemnification obligations provided for in Section 7. It is the intent of the Parties that this paragraph 5.c. supersede all but the first paragraph of Section 5 of the Existing Agreement.

6. Force Majeure.

If either Party is delayed or hindered in, or prevented from the performance required under this Supplement, other than the payment of money, by reason of strikes, lockouts, labor troubles, failure of power, riots, insurrection, war, acts of God, pandemic, or other reason of like nature not the fault of the Party delayed in performing work or doing acts, such Party is excused from such performance for the period of delay, provided that the Party claiming Force Majeure has notified the other Party of the delay.

7. Indemnification

Subject to the limitations of the Oregon Tort Claims Act and the Oregon Constitution, Customer shall,

to the fullest extent permitted by law, protect, defend, indemnify and hold harmless, PGE and its affiliates and their respective employees, directors, and agents ("Indemnitees") from and against any losses, costs, claims, penalties, fines, liens, demands, liabilities, legal actions, judgments, and expenses of every kind (including, without limitation, reasonable attorneys' fees, including at trial and on appeal) asserted or imposed against any Indemnitees by any third party (including, without limitation, employees of Customer or PGE) and arising out of the negligent or wrongful acts or omissions of Customer or any subcontractor of or consultant to Customer or any of their respective employees, directors or agents arising out of or in any way related to the performance or nonperformance of this Supplement ("Indemnified Losses"), except to the extent such Indemnified Losses are caused by the sole negligence or willful misconduct of the Indemnitees.

Customer warrants to PGE that its indemnity obligation will be supported by liability insurance to be furnished by it, or self-insurance approved by PGE for these purposes, provided that recovery under or in respect of this indemnity shall not be limited to the proceeds of any insurance.

8. Disclaimer of Consequential Damages

EXCEPT TO THE EXTENT REQUIRED BY LAW, PGE SHALL NOT BE LIABLE TO CUSTOMER FOR ANY LOST OR PROSPECTIVE PROFITS OR ANY OTHER SPECIAL, PUNITIVE, EXEMPLARY, CONSEQUENTIAL, INCIDENTAL OR INDIRECT LOSSES OR DAMAGES (IN TORT, CONTRACT OR OTHERWISE) UNDER OR IN RESPECT OF THIS SUPPLEMENT.

9. Successors and Assigns

This Supplement shall inure to the benefit of and be binding upon each of the Parties and, to the extent applicable, to each of their respective successors and permitted assigns. Customer may assign this Supplement to a third party or a successor-in-interest as long as a) Customer is assigning the Existing Agreement to the same assignee; b) in PGE's reasonable judgment such third party's or successor's creditworthiness and ability to perform Customer's obligations under this Supplement are at least as good as that of Customer; and b) the assignee or successor agrees to be bound by all the terms and conditions of this Supplement and the Existing Agreement.

10. Early Termination

a) This Supplement may be terminated by Customer upon 30 days' written notice to PGE, provided that, upon termination, Customer pays to PGE the amount that PGE's depreciated investment in any such additional alternate service facilities (installed to increase the capacity to serve Customer at such location and pursuant to this Supplement) exceeds the current value of those facilities to PGE. The Parties expressly intend this paragraph 10.a. to supersede the full second paragraph of Section 8 of the Existing Agreement.

b) Either Party may unilaterally terminate this Supplement, without consequence, in the event the Parties enter into a new supplement solely for purpose of increasing the amount of reserved capacity for alternate service required by Customer at the same location and service point identified in Section 4 above.

c) PGE may terminate this Supplement for Customer's failure to make timely payment of costs identified in Section 5, if, after 30 days' notice and a reasonable opportunity to cure, Customer fails to bring its account current with respect to such costs. Upon such termination Customer shall pay to PGE 1) if applicable, the amount that PGE's depreciated investment in any Alternate Service Facilities installed to serve Customer at the location identified in Section 4, exceeds the then current value of the facilities to PGE, as determined by PGE, and 2) the costs for removal of any such Alternate Service Facilities

as PGE may deem appropriate.

d) In the event that Customer fails to prevent excess kVA demand and refuses to execute a new or supplemental agreement with PGE for an additional amount of reserved capacity above 1600 kVA, then, upon written notice to Customer, PGE may terminate both this Supplement and the Existing Agreement. Upon such termination Customer shall pay to PGE 1) if applicable, the amount that PGE's depreciated investment in any Alternate Service Facilities installed to serve Customer at the location identified in Section 4, exceeds the then current value of the facilities to PGE, as determined by PGE, and 2) the costs for removal of any such Alternate Service Facilities as PGE may deem appropriate. The availability of alternate electric service following termination of this Supplement and the Existing Agreement is subject to all changes that may have occurred in applicable tariffs, including Utility Rules and Regulations and all lawful orders of the Public Utility Commission of Oregon, and it is understood that terms and conditions, different from those contained within this Supplement, may apply.

11. Miscellaneous

a) This Supplement shall be treated as a supplement to the Existing Agreement for the duration of this Supplement unless the terms of this Supplement make clear that certain provisions of the Existing Agreement are being superseded. After this Supplement expires or is earlier terminated, the Existing Agreement shall revert to its pre-Supplement terms and conditions, unless also terminated.

b) In the event of any discrepancy or inconsistency with the terms and conditions of the Existing Agreement, the terms and conditions of this Supplement shall govern and control for as long as this Supplement remains in effect.

c) This Supplement shall be interpreted, governed by, and construed in accordance with the laws of the State of Oregon, without regard to the conflict of law provisions of such State. With respect to any suit, action or proceedings related to this Supplement and the Existing Agreement (the "Proceedings"), each Party irrevocably submits to the exclusive jurisdiction of the courts of the State of Oregon and the United States District Court located in Multnomah County, Oregon.

d) This Supplement may be executed in counterparts, each of which is deemed an original, but collectively they constitute one and the same document. Delivery of an executed counterpart of this Supplement electronically or by facsimile shall be effective as delivery of an original executed counterpart of this Supplement.

[THE REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK; THE SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the undersigned parties have executed this First Supplement to Agreement for Primary Voltage Alternate Electric Service Under Schedule 83, this 19th day of November, 2021.

CUSTOMER: WATER ENVIRONMENT SERVICES

(Signature)

(Title)

(Date)

UTILITY: PORTLAND GENERAL ELECTRIC COMPANY

John McFarland (Nov 22, 2021 08:27 PST)

clc

(Signature)

Chief Customer Officer

(Title)

Nov 22, 2021

(Date)

Reviewed and approved by PGE's Rates and Regulatory Affairs Dept. JT

Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

December 2, 2021

Housing Authority Board of Commissioners
Clackamas County

Members of the Board:

Approval of a HACC Resolution No. 1958 Delegating an Authorized Representative(s) to act on behalf of the Housing Authority of Clackamas County to finalize the Regional Affordable Housing Bond and the Project-Based Voucher Contract for the Good Shepherd Village development in Happy Valley. Funding sources for this development include Regional Affordable Housing Bond funds and Section 8 Project Based Vouchers
No County General Funds Involved

Purpose/Outcomes	Approval of Resolution No. 1958 for the Delegation of Authority for the documents related to the Regional Affordable Housing Bond Loan and Section 8 and Mainstream Project-Based Vouchers allotted for the Good Shepherd Village development in Happy Valley.
Dollar Amount and Fiscal Impact	$18,330,000 in Regional Affordable Housing Bond funds and 35 Section 8 and Mainstream Project-Based Vouchers
Funding Source	No County funds are involved
Duration	Financial closing scheduled on February 3, 2022
Previous Board Action/Review	7/23/20 – Housing Authority Board endorses three projects from first Regional Affordable Housing Bond fund NOFA including Good Shepherd Village
Counsel Review	11/16/21, Paul Dagle, Elliott, Ostrander & Preston, P.C.
Strategic Plan Alignment	1. Sustainable and affordable housing 2. Ensure safe, healthy and secure communities
Contact Person	Toni Karter, Interim Executive Director, Housing Authority 503-650-3139

Staff is requesting the approval of Resolution No.1958 to provide Delegation of Authority to an Authorized Representative(s) to act on behalf of the Housing Authority to finalize the terms of, execute, acknowledge, and deliver documents related to the Regional Affordable Housing Bond Loan and the Project-Based Voucher contract for the Good Shepherd Village project. Good Shepherd Village is one of three projects awarded bond funds and Section 8 and Mainstream project based vouchers in the County's first round solicitation for Regional Affordable Housing Bond fund. The project is scheduled to close construction financing in the first quarter of 2022. Timely approval of the resolution before the end of the calendar year will ensure the bond project moves forward on schedule and further advances County affordable housing goals established in the Local Implementation Strategy.

BACKGROUND:

Good Shepherd Village is the first regulated affordable housing development in Happy Valley. The development will include 143 units ranging in size from studios to three-bedrooms. The project includes 35 Permanent Supportive Housing (PSH) units reserved for households who

have experienced houselessness or are at risk of becoming houseless, including 15 apartments expressly for Veterans and 5 apartments for nonelderly and disabled households. Regional Affordable Housing Bond funds dedicated to this project total $18,330,000. Other funding for this project includes 4% Low Income Housing Tax Credit equity, OHCS Permanent Supportive Housing funds, OHCS Energy Program funds, 35 Project-based vouchers, tax-exempt debt, private funding, and donated land.

Good Shepherd Village Timeline:

11/4/2019 – Local Implementation Strategy (LIS) and Intergovernmental Agreement between HACC and Metro for Regional Affordable Housing Bonds were approved and adopted.

1/22/20 – First Notice of Funding Availability (NOFA) was released for Regional Affordable Housing Bond Funds. HACC allotted 125 Section 8 Project-Based Vouchers to projects awarded.

4/20/20 – NOFA applications were received for 5 projects.

7/23/20 – Housing Authority Board endorses three projects including Good Shepherd Village.

12/2/21 – Resolution No. 1958 for the Delegation of Authority to finalize the Regional Affordable Housing Bond Loan and the Project-Based Voucher Contract for the Good Shepherd Village development in Happy Valley brought to the Housing Authority Board for approval.

ATTACHMENTS:

- Resolution No. 1958 Authorizing Loan of Regional Affordable Housing Bond Funds and award of 35 Project-Based Vouchers to support the development of Good Shepherd Village
- Project Information Sheet: Good Shepherd Village

RECOMMENDATION:

HACC staff recommends the approval of Resolution No.1958 Delegating an Authorized Representative(s) to act on behalf of the Housing Authority of Clackamas County to finalize the Regional Affordable Housing Bond Loan and the Project-Based Voucher Contract for the Good Shepherd Village development in Happy Valley.

Respectfully submitted,

Rodney Cook

Rodney A. Cook, Director
Health, Housing and Human Services

BEFORE THE BOARD OF COMMISSIONERS

OF THE HOUSING AUTHORITY OF CLACKAMAS COUNTY

In the Matter of Authorizing the Metro Bond Funds Loan Financing and Related Matters, for the Good Shepherd Apartments Project	RESOLUTION NO. 1958 *Page 1 of 4*

WHEREAS, the Housing Authority of Clackamas County ("***Authority***") works to provide affordable multifamily housing ("***Affordable Housing***") for persons and families of lower income pursuant to Oregon Revised Statutes ("ORS") 456.005 through 456.235; and,

WHEREAS, the Metro Housing Bond sponsored by Metro was approved by voters in the Metro Region in 2018 to provide funding within the Metro Region for Affordable Housing ("***Metro Bond Funds***"); and

WHEREAS, the Authority acting on behalf of Clackamas County, Oregon has been designated as the agency for the County to apply for such Metro Bond Funds and to loan such funds to developers of Affordable Housing; and

WHEREAS, Good Shepherd Limited Partnership (the "***Partnership***") applied to the Authority for a loan of Metro Bond Funds in the amount up to Eighteen Million Three Hundred Thirty Thousand Dollars ($18,330,000) (the "***Metro Bond Funds Loan***") to be used in connection with the development of Good Shepherd Apartments, with a property address of 12596 SE 162nd Avenue, Happy Valley, Oregon (the "***Project***"); and

WHEREAS, the Authority has applied to Metro to be allocated Metro Bond Funds in the amount up to Eighteen Million Three Hundred Thirty Thousand Dollars ($18,330,000) to be loaned to the Partnership to use in connection with the development of the Project and has received final approval for the award of such Metro Bond Funds; and

WHEREAS, the Authority desires to make a loan to the Partnership of the Metro Bond Funds in the amount of up to Eighteen Million Three Hundred Thirty Thousand Dollars ($18,330,000); and

WHEREAS, the Partnership has requested the award of up to thirty-five (35) Project-Based Vouchers in connection with the development of the Project; and

WHEREAS, the United States Department of Housing and Urban Development (HUD) requires the approval of the Authority in connection with their consideration and approval of any award of Project-Based Vouchers; and

WHEREAS, the Authority will apply to HUD for such approval; and

WHEREAS, subject to the approval of HUD, the Authority desires to award up to 35 Project-Based Vouchers to the Partnership to be awarded to the Project on its completion; and

WHEREAS, upon receipt of HUD approval, the Authority desires to enter into Agreement to Enter into a Housing Assistance Payment Contracts (the "***AHAP Contracts***") which will provide that upon timely completion of the Project, 35 Project-Based Vouchers will be awarded pursuant to the Project-Based Voucher Program Housing Assistance Payment Contracts (the "***HAP Contracts***");

NOW, THEREFORE, THE AUTHORITY ADOPTS THE FOLLOWING RESOLUTIONS:

Section 1. Approve Metro Bond Funds Loan to the Partnership.

BE IT RESOLVED, that the Authority is authorized to negotiate, execute and deliver on behalf of the Authority the Metro Bond Funds Loan Documents listed on the attached ***Exhibit A*** (whether bearing the name listed or names to similar effect) and such other documents as reasonably may be required in connection with the Metro Bond Funds Loan all in the form approved by any single Authorized Representative (such approval to be conclusively demonstrated by the signature of any single Authorized Representative on such documents).

Section 2. Approve Award of 35 Project Based Vouchers.

BE IT RESOLVED, that, subject to HUD approval, the Authority is authorized to award thirty-five (35) Project-Based Vouchers to the Partnership (the "***Project Based Vouchers***"); and

BE IT FURTHER RESOLVED, that the Authority is authorized to negotiate, execute and deliver on behalf of the Authority the AHAP Contracts and the HAP Contracts with the Partnership relating to the Project-Based Vouchers listed on the attached ***Exhibit A*** (whether bearing the name listed or names to similar effect) and such other documents as reasonably may be required in connection with the award of the Project-Based Vouchers all in the form approved by any single Authorized Representative (such approval to be conclusively demonstrated by the signature of any single Authorized Representative on such documents).

Section 3. Delegation.

BE IT RESOLVED, that the Executive Director of the Authority, the Director of Health, Housing and Human Services, and the Director of Housing Development is each an Authorized Representative, as that term is used in these Resolutions, and each may individually, on behalf of the Authority, and without further action by the Board, finalize the terms of, execute, acknowledge, and deliver the actions and documents authorized herein.

DRAFT

Section 4. General Resolutions Authorizing and Ratifying Other Actions.

BE IT RESOLVED, that any Authorized Representative is authorized to negotiate, execute and deliver on behalf of the Authority such other agreements, certificates, and documents, and to take or authorize to be taken all such other actions any Authorized Representative shall deem necessary or desirable to carry out the transactions contemplated by the foregoing resolutions (such determination to be conclusively demonstrated by the signature of any single Authorized Representative on such document); and

BE IT FURTHER RESOLVED, that to the extent any action, agreement, document or certification has heretofore been taken, executed, delivered or performed by an Authorized Representative named in these Resolutions on behalf of the Authority to carry out the transactions contemplated by the foregoing resolutions, the same is hereby ratified and affirmed.

NOW, THEREFORE, BE IT RESOLVED, that the Chair or one of the Directors may finalize negotiations, execute, acknowledge and deliver the Documents and any other documents and take any actions that are necessary or desirable to complete the Documents, this Resolution and Order.

DATED THIS _____ DAY OF DECEMBER 2021

BOARD OF COMMISSIONERS FOR THE
HOUSING AUTHORITY OF CLACKAMAS COUNTY

_____
Chair

_____
Recording Secretary

APPROVED AS TO FORM

_____
COUNSEL FOR HOUSING AUTHORITY
OF CLACKAMAS COUNTY, OREGON

EXHIBIT A

Metro Bond Funds Loan Documents

1. Loan Agreement (Good Shepherd Apartments)

2. Metro Bond Program Promissory Note (Good Shepherd Apartments)

3. Line of Credit Trust Deed, Security Agreement, Fixture Filing and Assignment of Leases and Rents (Good Shepherd Apartments)

4. Regulatory Agreement

5. Replacement Cost and Capital Improvements Agreement

6. Priority and Subordination Agreement

Project Based Voucher Documents

1. Agreement to Enter into a Housing Assistance Payment (AHAP) Contracts and any applicable Riders

2. Housing Assistance Payment Payments (HAP) Contracts and any applicable Riders

Other Related Documents

1. Any other documents that are necessary or desirable to be executed and delivered in connection with the Metro Bond Funds Loan as determined by the Executive Director of the Authority; and

2. Any documents that are necessary or desirable to be executed and delivered in connection with the closing of the term loan and repayment of the construction loan pursuant to the provisions of the loan documents as determined by the Executive Director of the Authority.

DRAFT

At a glance

Total unit count: 143

Total development cost: $60 million

Regional Affordable Housing Bond funds: $18.3 million

Bond funds per unit: $128,000

Project type: New construction

Sponsor: Caritas Community Housing Corporation

Development consultant: Housing Development Center

Architect: MWA Architects

General contractor: Walsh Construction

Partners: Familias en Accion, APANO, El Programa Hispano, Quantum Residential

Funding: Low Income Housing Tax Credits, OHCS Permanent Supportive Housing Funds, OHCS Energy Program, Regional Affordable Housing Bond, Project-based Section 8 vouchers, private funding, donated land

Construction begins: February 2022

Anticipated completion: July 2023

Good Shepherd Village

SE 162nd - Happy Valley - Caritas Community Housing Corporation

Good Shepherd Village, the first regulated affordable housing development in Happy Valley, will be 143 units from studios to three-bedrooms, including 35 project-based vouchers. The project sets aside 35 apartments of Permanent Supportive Housing (PSH) for those who have experienced houselessness or are at risk of bing houseless, including 15 apartments expressly for Veterans. Residents will have convenient access to public transit, grocery stores, schools, a public library, multiple parks and healthcare resources.

In 2012, the Brockamp Family donated 11 acres in Happy Valley to Catholic Charities of Oregon (CCO) for affordable housing. The property offers a beautiful four-acre natural area in the northeast part of the site.

The three-bedrooms and several of the two-bedroom units will be focused in two buildings each surrounding a small courtyard. A third building will house all of the studios, one-bedrooms, and remaining two-bedrooms, as well as community rooms and office space for resident and supportive services. Each building will also provide laundry facilities and secure bike parking for residents. The site will include parking and outdoor gathering and play areas. The project uses trauma-informed design, universal design, and sustainable design elements.

Catholic Charities of Oregon is called by a tradition of social justice to the work of equity and inclusion. CCO works to advance equity for immigrants, refugees, and people who are homeless and vulnerable, with a special emphasis on those who are not served by other providers. Good Shepherd Village will serve priority populations with a broad range of needs based on an analysis of people living and/or working in Happy Valley. Services will be provided by Catholic Charities of Oregon in addition to project partners, and the housing arm of CCO, Caritas Housing, will act as the developer.

Catholic Charities · Caritas Housing · Housing Authority of Clackamas County · Clackamas County

Development program

Good Shepherd is 143 units of new affordable housing and includes 35 project-based vouchers and one management unit.

Unit size (no. of bedrooms)	No. of units	AMI%	PBVs	Square feet/ unit	Gross monthly rent/unit
Studio	8	30%	8	400	$507
Studio	5	60%	0	400	$1015
One bedroom	22	30%	17	550	$544
One bedroom	28	60%	0	550	$1,088
Two bedroom	19	30%	5	850	$653
Two bedroom	41	60%	0	850	$1,306
Three bedroom	9	30%	5	1,100	$754
Three bedroom	10	60%	0	1,100	$1,509
Managment unit	1	NA	0	1,100	$0
Total	143		35		

Amenities

- Two public elementary schools within one mile
- Transit within 1/4 mile and one mile
- Providence Clinic within 1/2 mile
- Library within one mile
- Multiple parks and recreation areas within 1/4 mile
- Secure bike parking
- On site community rooms
- On site management and services offices and meeting spaces
- Outdoor play areas
- In unit heating and cooling

Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

December 2, 2021

Housing Authority Board of Commissioners
Clackamas County

Members of the Board:

Approval of HACC Resolution No. 1959 Delegating an Authorized Representative(s) to act on behalf of the Housing Authority of Clackamas County to finalize the Regional Affordable Housing Bond Loan and the Section 8 Project-Based Voucher Contract for the Maple Apartments development in Oregon City. Funding sources for this development include Regional Affordable Housing Bond funds and Section 8 Project Based Vouchers
No County General Funds Involved

Purpose/Outcomes	Approval of Resolution No. 1959 for the Delegation of Authority for the closing documents for the Regional Affordable Housing Bond Loan and Section 8 Project-Based Vouchers allotted for the Maple Apartments development in Oregon City.
Dollar Amount and Fiscal Impact	$15,903,000 in Regional Affordable Housing Bond funds and 70 Section 8 Project-Based Vouchers
Funding Source	No County funds are involved
Duration	Financial closing scheduled on March 3, 2022
Previous Board Action/Review	7/23/20 – Housing Authority Board endorses three projects from first Regional Affordable Housing Bond fund NOFA including Maple Apartments
Counsel Review	11/16/21, Paul Dagle, Elliott, Ostrander & Preston, P.C.
Strategic Plan Alignment	1. Sustainable and affordable housing 2. Ensure safe, healthy and secure communities
Contact Person	Toni Karter, Interim Executive Director, Housing Authority 503-650-3139

Staff is requesting the approval of Resolution No.1959 to provide Delegation of Authority to an Authorized Representative(s) to act on behalf of the Housing Authority to finalize the terms of, execute, acknowledge, and deliver documents related to the Regional Affordable Housing Bond Loan and the Section 8 Project-Based Voucher contract for the Maple Apartments project. Maple Apartments is one of three projects awarded bond funds and Section 8 vouchers in the County's first round solicitation for Regional Affordable Housing Bond fund. The project is scheduled to close construction financing in the first quarter of 2022. Timely approval of the resolution before the end of the calendar year will ensure the bond project moves forward on schedule and further advances County affordable housing goals established in the Local Implementation Strategy.

BACKGROUND:

Maple Apartments is a 171 unit affordable housing development located in Oregon City. Designed with agricultural workers and low-income families in mind, units are a mix of one, two, three and four bedrooms, with 75% of units two-bedrooms and larger. 70 units will be reserved for households with incomes at or below 30% Area Median Income. 43 units are set

aside for agricultural workers and field laborers and their families. Maple will provide year-round, off-farm, permanent housing with programmatic elements designed with farmworkers in mind. Nine units are reserved for permanent housing for people experiencing houselessness or are at risk of becoming houseless. Regional Affordable Housing Bond funds dedicated to this project total $15,903,000. Other funding for this project includes 4% Low Income Housing Tax Credit equity, Agriculture Workforce Housing Tax Credit equity, 70 Project-based Section 8 Vouchers, tax-exempt debt and private funding.

Maple Apartments Timeline:

11/4/2019 – The Local Implementation Strategy and an Intergovernmental Agreement between HACC and Metro for Regional Affordable Housing Bonds were approved and adopted.

1/22/20 – First Notice of Funding Availability (NOFA) was released for Regional Affordable Housing Bond funds. HACC allotted 125 Section 8 Project-Based Vouchers to projects awarded Bond funds.

4/20/20 – NOFA applications were received for 5 projects.

7/23/20 – Housing Authority Board endorses three projects including Maple Apartments.

12/2/21 – Resolution No. 1959 for the Delegation of Authority to finalize the Regional Affordable Housing Bond Loan and the Section 8 Project-Based Voucher Contract for the Maple Apartments development in Oregon City brought to the Housing Authority Board for approval.

ATTACHMENTS:

- Resolution No. 1959 granting Delegation of Authority for the closing documents for the Regional Affordable Housing Bond Loan and Section 8 Project-Based Vouchers allotted for the Maple Apartments development in Oregon City.
- Project Information Sheet: Maple Apartments

RECOMMENDATION:

HACC staff recommends the approval of Resolution No.1959 for Delegating an Authorized Representative(s) to act on behalf of the Housing Authority of Clackamas County to finalize the Regional Affordable Housing Bond Loan and the Section 8 Project-Based Voucher Contract for the Maple Apartments development in Oregon City.

Respectfully submitted,

Rodney Cook

Rodney A. Cook, Director
Health, Housing and Human Services

BEFORE THE BOARD OF COMMISSIONERS

OF THE HOUSING AUTHORITY OF CLACKAMAS COUNTY

In the Matter of Authorizing the Metro Bond Funds Loan Financing and Related Matters, for the Maple Apartments

RESOLUTION NO. 1959

WHEREAS, the Housing Authority of Clackamas County ("***Authority***") works to provide affordable multifamily housing ("***Affordable Housing***") for persons and families of lower income pursuant to Oregon Revised Statutes ("ORS") 456.005 through 456.235; and,

WHEREAS, the Metro Housing Bond sponsored by Metro was approved by voters in the Metro Region in 2018 to provide funding within the Metro Region for Affordable Housing ("***Metro Bond Funds***"); and

WHEREAS, the Authority acting on behalf of Clackamas County, Oregon has been designated as the agency for the County to apply for such Metro Bond Funds and to loan such funds to developers of Affordable Housing; and

WHEREAS, Maple OC Limited Partnership (the "***Partnership***") applied to the Authority for a loan of Metro Bond Funds in the amount up to Fifteen Million Nine Hundred Three Thousand Dollars ($15,903,000) (the "***Metro Bond Funds Loan***") to be used in connection with the development of Maple Apartments, with a property address of 14268 Maplelane Court, Oregon City, Oregon (the "***Project***"); and

WHEREAS, the Authority has applied to Metro to be allocated Metro Bond Funds in the amount up to Fifteen Million Nine Hundred Three Thousand Dollars ($15,903,000) to be loaned to the Partnership to use in connection with the development of the Project and has received final approval for the award of such Metro Bond Funds; and

WHEREAS, the Authority desires to make a loan to the Partnership of the Metro Bond Funds in the amount of up to Fifteen Million Nine Hundred Three Thousand Dollars ($15,903,000); and

WHEREAS, the Partnership has requested the award of up to seventy (70) Project-Based Section 8 Vouchers in connection with the development of the Project; and

WHEREAS, the United States Department of Housing and Urban Development (HUD) requires the approval of the Authority in connection with their consideration and approval of any award of Project Based Section 8 Vouchers; and

WHEREAS, the Authority will apply to HUD for such approval; and

WHEREAS, subject to the approval of HUD, the Authority desires to award 70 Project Based Section 8 Vouchers to the Partnership to be awarded to the Project on its completion; and

WHEREAS, upon receipt of HUD approval, the Authority desires to enter into an Agreement to Enter Into A Housing Assistance Payment Contract (the "***AHAP Contract***") which will provide that upon timely completion of the Project the 70 Section 8 Project Vouchers will be awarded pursuant to the Section 8 Project-Based Voucher Program Housing Assistance Payment Contract (the "***HAP Contract***");

NOW, THEREFORE, THE AUTHORITY ADOPTS THE FOLLOWING RESOLUTIONS:

Section 1. Approve Metro Bond Funds Loan to the Partnership.

BE IT RESOLVED, that the Authority is authorized to negotiate, execute and deliver on behalf of the Authority the Metro Bond Funds Loan Documents listed on the attached ***Exhibit A*** (whether bearing the name listed or names to similar effect) and such other documents as reasonably may be required in connection with the Metro Bond Funds Loan all in the form approved by any single Authorized Representative (such approval to be conclusively demonstrated by the signature of any single Authorized Representative on such documents).

Section 2. Approve Award of 70 Project Based Vouchers

BE IT RESOLVED, that, subject to HUD approval, the Authority is authorized to award seventy (70) Section 8 Project Based Vouchers to the Partnership (the "***Project Based Vouchers***"); and

BE IT FURTHER RESOLVED, that the Authority is authorized to negotiate, execute and deliver on behalf of the Authority the AHAP Contract and the HAP Contract with the Partnership relating to the Project Based Vouchers listed on the attached ***Exhibit A*** (whether bearing the name listed or names to similar effect) and such other documents as reasonably may be required in connection with the award of the Project Based Vouchers all in the form approved by any single Authorized Representative (such approval to be conclusively demonstrated by the signature of any single Authorized Representative on such documents).

Section 3. Delegation.

BE IT RESOLVED, that the Executive Director of the Authority, the Director of Health, Housing and Human Services, and the Director of Housing Development is each an Authorized Representative, as that term is used in these Resolutions, and each may individually, on behalf of the Authority, and without further action by the Board, finalize the terms of, execute, acknowledge, and deliver the actions and documents authorized herein.

Section 4. General Resolutions Authorizing and Ratifying Other Actions.

BE IT RESOLVED, that any Authorized Representative is authorized to negotiate, execute and deliver on behalf of the Authority such other agreements, certificates, and documents, and to take or authorize to be taken all such other actions any Authorized Representative shall deem necessary or desirable to carry out the transactions contemplated by the foregoing resolutions (such determination to be conclusively demonstrated by the signature of any single Authorized Representative on such document); and

BE IT FURTHER RESOLVED, that to the extent any action, agreement, document or certification has heretofore been taken, executed, delivered or performed by an Authorized Representative named in these Resolutions on behalf of the Authority to carry out the transactions contemplated by the foregoing resolutions, the same is hereby ratified and affirmed.

NOW, THEREFORE, BE IT RESOLVED, that the Chair or one of the Directors may finalize negotiations, execute, acknowledge and deliver the Documents and any other documents and take any actions that are necessary or desirable to complete the Documents, this Resolution and Order.

DATED THIS _____ DAY OF DECEMBER 2021

BOARD OF COMMISSIONERS FOR THE
HOUSING AUTHORITY OF CLACKAMAS COUNTY

_____
Chair

_____
Recording Secretary

APPROVED AS TO FORM

_____
COUNSEL FOR HOUSING AUTHORITY
OF CLACKAMAS COUNTY, OREGON

EXHIBIT A

Metro Bonds Funds Loan Documents

1. Loan Agreement (Maple Apartments)

2. Metro Bond Program Promissory Note (Maple Apartments)

3. Line of Credit Trust Deed, Security Agreement, Fixture Filing and Assignment of Leases and Rents (Maple Apartments)

4. Regulatory Agreement

5. Replacement Cost and Capital Improvements Agreement

6. Priority and Subordination Agreement

Project Based Voucher Documents

1. Agreement to Enter into a Housing Assistance Payment Contract and any applicable Riders

2. Housing Assistance Payment Payments (HAP) Contract and any applicable Riders

Other Related Documents

1. Any other documents that are necessary or desirable to be executed and delivered in connection with the Metro Bonds Funds Loan as determined by the Executive Director of the Authority; and

2. Any documents that are necessary or desirable to be executed and delivered in connection with the closing of the term loan and repayment of the construction loan pursuant to the provisions of the loan documents as determined by the Executive Director of the Authority.

At a glance

Total unit count: 171

Total development cost: $62.6 million

Regional Affordable Housing bond funds: $15.9 million

Bond funds per unit: $93,000

Project type: New construction

Sponsor: Community Development Partners and Hacienda CDC

Architect: Salazar

General contractor: LMC Construction

Partner: Guardian Property Management

Funding: Low Income Housing Tax Credits, Agriculture Workforce Housing Tax Credit, Regional Affordable Housing Bond, Project-based Section 8 Vouchers, private funding

Construction begins: March 2022

Anticipated completion: November 2023

Maple Apartments

S. Beavercreek Rd - Oregon City - Community Development Partners and Hacienda CDC

Maple Apartments, a partnership between Community Development Partners and Hacienda CDC, is a multi-building complex set around a gracious central green space to be designed as a publicly accessible park. Units are a mix of one, two, three and four bedrooms, with 75% being two-bedroom and larger. CDP and Hacienda have designed Maple to house and support several high barrier groups, including:

- Agricultural workers – supported by the Agriculture Workforce Housing Tax Credit (AWHTC), 12 units are set aside for agricultural workers and their families. Maple will provide year-round, off-farm, permanent housing with programmatic elements designed with farmworkers in mind.
- Field laborers – 31 additional units for field laborers and their families. Similar to agricultural workers but not included as part of the above grant.
- Families at or below 30% AMI including people with rental barriers – 70 project-based vouchers to support these vulnerable households.
- Homeless households – 9 units set aside for permanent housing for people who have been houseless.

Located minutes from Clackamas Community College in Oregon City, the site rests on a hillside abutting a quiet residential neighborhood. The site design includes a series of amenities (community gardens, walking paths, play areas, picnic/BBQ areas and parking spaces) within a park-like setting, preserving several clusters of existing mature trees. The project also includes a community room, book share library, computer stations and demonstration kitchen for events/classes.

C D P Community Development Partners

HACIENDA COMMUNITY DEVELOPMENT CORP.

Housing Authority of Clackamas County

CLACKAMAS COUNTY

Development program

Maple is 171 units, with 70 project-based vouchers. Designed with immigrant, agricultural worker and low-income families in mind, 75% of units are two-bedroom and bigger.

Unit size (no. of bedrooms)	No. of units	AMI%	PBVs	Square feet/ unit	Gross monthly rent/unit
One bedroom	24	30%	24	549	$544
One bedroom	18	60%	0	549	$1,088
Two bedroom	29	30%	29	796	$653
Two bedroom	25	60%	0	796	$1,306
Three bedroom	17	30%	17	1,027	$755
Three bedroom	49	60%	0	1,027	$1,509
Four bedroom	9	60%	0	1,300	$1,683
Total	**171**		**70**		

Amenities

- One grocery within 1/4 mile, and two more within one mile
- Community garden, walking paths and outdoor BBQ area
- 174 parking spaces
- Community spaces such as a book share room and demonstration kitchen
- Clackamas Community College less than half a mile away

Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

December 2, 2021

Board of Commissioners
Clackamas County

Members of the Board:

Approval of an Intergovernmental Agreement with Multnomah County for Psychiatric Consultation Services. Maximum agreement value shall not exceed $14,700.00. Funding through Community Mental Health Program (CMHP) and Oregon Health Plan (OHP) funds.
No County General Funds involved.

Purpose/Outcomes	To provide psychiatric consultation and expert opinion to Clackamas County Behavioral Health.
Dollar Amount and Fiscal Impact	The contract maximum is $14,700.
Funding Source	No County General Funds are involved. Community Mental Health Program (CMHP) and Oregon Health Plan (OHP) funds.
Duration	Effective upon signature and terminates on December 31, 2022.
Previous Board Action	Issues November 30, 2021
Counsel Review	Reviewed and approved May 17, 2021 Kathleen Rastetter
Procurement Review	Was this item reviewed by Procurement? No Review not required for intergovernmental agreements.
Strategic Plan Alignment	Ensuring safe, healthy and secure communities through the provision of mental health and substance use services.
Contact Person	Mary Rumbaugh, Director – Behavioral Health Division – 503-742-5305
Agreement No.	10122

BACKGROUND:
The Behavioral Health Division of the Health, Housing & Human Services Department requests the approval of an Intergovernmental Agreement (IGA) with Multnomah County for psychiatric consultation and expert opinion on cases involving Non-Medicaid clients receiving care coordination services through Clackamas County Behavioral Health Division; provide guidance to Mental Health Abuse Investigators; and crisis and safety net programs as needed.

This IGA, reviewed and approved by Counsel May 17, 2021, is effective upon signature through December 31, 2022, and has a maximum value of $14,700.00.

RECOMMENDATION:
Staff recommends the Board approval of this Agreement.

Respectfully submitted,

Rodney Cook

Rodney A. Cook, Director
Health, Housing and Human Services

INTERGOVERNMENTAL AGREEMENT

BETWEEN

CLACKAMAS COUNTY,
HEATLH, HOUSING AND HUMAN SERVICES DEPARTMENT,
BEHAVIORAL HEALTH DIVISION

AND

MULTNOMAH COUNTY,
HEALTH DEPARTMENT, MENTAL HEALTH AND ADDICTIONS DIVISION

Agreement #10122

THIS AGREEMENT (this "Agreement") is entered into and between Clackamas County ("Clackamas") and Multnomah County ("Multnomah"), both political subdivisions of the State of Oregon, collectively referred to as the "Parties" and each a "Party."

RECITALS

Oregon Revised Statutes Chapter 190.010 confers authority upon local governments to enter into agreements for the performance of any and all functions and activities that a party to the agreement, its officers or agencies have authority to perform.

In consideration of the mutual promises set forth below and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereby agree as follows:

TERMS

1. **Term.** This Agreement shall be effective upon execution, and shall expire upon the completion of each and every obligation of the Parties set forth herein, or **December 31, 2022**, whichever is sooner.
2. **Scope of Work.** Multnomah agrees to provide the services further identified in the Scope of Work attached hereto as Exhibit A and incorporated herein ("Work").
3. **Consideration.** Clackamas agrees to pay Multnomah, from available and authorized funds, a sum not to exceed **fourteen thousand seven hundred dollars ($14,700.00)** for accomplishing the Work required by this Agreement.
4. **Payment.** Unless otherwise specified, Multnomah shall submit monthly invoices for Work performed and shall include the total amount billed to date by Multnomah prior to the current invoice. Invoices shall describe all Work performed with particularity, by whom it was performed, and shall itemize and explain all expenses for which reimbursement is claimed. Payments shall be made to Multnomah following Clackamas' review and approval of invoices submitted by Multnomah. Multnomah shall not submit invoices for, and Clackamas will not pay, any amount in excess of the maximum compensation amount set forth above.
5. **Representations and Warranties.**
   A. *Multnomah Representations and Warranties*: Multnomah represents and warrants to Clackamas that Multnomah has the power and authority to enter into and perform this Agreement, and this Agreement, when executed and delivered, shall be a valid and binding obligation of Multnomah enforceable in accordance with its terms.

   B. *Clackamas Representations and Warranties*: Clackamas represents and warrants to Multnomah that Clackamas has the power and authority to enter into and perform this Agreement, and this Agreement, when executed and delivered, shall be a valid and binding obligation of Clackamas enforceable in accordance with its terms.

C. The warranties set forth in this section are in addition to, and not in lieu of, any other warranties provided.

6. **Termination.**

A. Either Clackamas or Multnomah may terminate this Agreement at any time upon thirty (30) days written notice to the other party.

B. Either the Clackamas or Multnomah may terminate this Agreement in the event of a breach of the Agreement by the other. Prior to such termination however, the Party seeking the termination shall give the other Party written notice of the breach and of the Party's intent to terminate. If the breaching Party has not entirely cured the breach within fifteen (15) days of deemed or actual receipt of the notice, then the Party giving notice may terminate the Agreement at any time thereafter by giving written notice of termination stating the effective date of the termination. If the default is of such a nature that it cannot be completely remedied within such fifteen (15) day period, this provision shall be complied with if the breaching Party begins correction of the default within the fifteen (15) day period and thereafter proceeds with reasonable diligence and in good faith to effect the remedy as soon as practicable. The Party giving notice shall not be required to give more than one (1) notice for a similar default in any twelve (12) month period.

C. Clackamas or Multnomah shall not be deemed to have waived any breach of this Agreement by the other Party except by an express waiver in writing. An express written waiver as to one breach shall not be deemed a waiver of any other breach not expressly identified, even though the other breach is of the same nature as that waived.

D. Either party may terminate this Agreement in the event that party fails to receive expenditure authority sufficient to allow the party, in the exercise of its reasonable administrative discretion, to continue to perform under this Agreement, or if federal or state laws, regulations or guidelines are modified or interpreted in such a way to either the Work under this Agreement is prohibited or the party is prohibited from paying for such work from the planned funding source.

E. Any termination of this Agreement shall not prejudice any rights or obligations accrued to the Parties prior to termination.

7. **Insurance.** The Parties agree to maintain levels of insurance, or self-insurance, sufficient to satisfy their obligations under this Agreement and all requirements under applicable law.

8. **Notices; Contacts.** Legal notice provided under this Agreement shall be delivered personally, by email or by certified mail to the individuals identified below. Any communication or notice so addressed and mailed shall be deemed to be given upon receipt. Any communication or notice sent by electronic mail to an address indicated herein is deemed to be received two (2) hours after the time sent (as recorded on the device from which the sender sent the email), unless the sender receives an automated message that the email has not been delivered. Any communication or notice by personal delivery shall be deemed to be given when actually delivered. Either Party may change the Party contact information, or the invoice or payment addresses by giving prior written notice thereof to the other Party at its then current notice address.

A. Meghan Tamargo, Compliance & Quality Management Supervisor, or their designee will act as liaison for the County.

Contact Information:

Phone: 503-742-5981
Email: MTamagro@clackamas.us

Julie Dodge, or their designee will act as liaison for the Agency.

Contact Information:

Phone: 503.988.4055
Email: julie.dodge@multco.us

9. **General Provisions.**

A. **Oregon Law and Forum.** This Agreement, and all rights, obligations, and disputes arising out of it will be governed by and construed in accordance with the laws of the State of Oregon. Any claim between Clackamas and Multnomah that arises from or relates to this Agreement shall be brought and conducted solely and exclusively within the Circuit Court of Marion County for the State of Oregon; provided, however, if a claim must be brought in a federal forum, then it shall be brought and conducted solely and exclusively within the United States District Court for the District of Oregon. In no event shall this section be construed as a waiver by Clackamas or Multnomah of any form of defense or immunity, whether sovereign immunity, governmental immunity, immunity based on the Eleventh Amendment to the Constitution of the United States or otherwise, from any claim or from the jurisdiction of any court. Clackamas and Multnomah, by execution of this Agreement, hereby consent to the in personam jurisdiction of the courts referenced in this section.

B. **Compliance with Applicable Law.** Both Parties shall comply with all applicable local, state and federal ordinances, statutes, laws and regulations. All provisions of law required to be a part of this Agreement, whether listed or otherwise, are hereby integrated and adopted herein.

C. **Non-Exclusive Rights and Remedies.** Except as otherwise expressly provided herein, the rights and remedies expressly afforded under the provisions of this Agreement shall not be deemed exclusive, and shall be in addition to and cumulative with any and all rights and remedies otherwise available at law or in equity. The exercise by either Party of any one or more of such remedies shall not preclude the exercise by it, at the same or different times, of any other remedies for the same default or breach, or for any other default or breach, by the other Party.

D. **Access to Records.** The parties shall retain, maintain, and keep accessible all records relevant to this Agreement ("Records") for a minimum of ten (10) years, following Agreement termination or full performance or any longer period as may be required by applicable law, or until the conclusion of an audit, controversy or litigation arising out of or related to this Agreement, whichever is later. The parties shall maintain all financial records in accordance with generally accepted accounting principles. All other Records shall be maintained to the extent necessary to clearly reflect actions taken. During this record retention period, the parties shall permit authorized representatives access to the Records at reasonable times and places for purposes of examining and copying.

E. **Debt Limitation.** This Agreement is expressly subject to the limitations of the Oregon Constitution and Oregon Tort Claims Act, and is contingent upon appropriation of funds. Any provisions herein that conflict with the above referenced laws are deemed inoperative to that extent.

F. **Severability.** If any provision of this Agreement is found to be unconstitutional, illegal or unenforceable, this Agreement nevertheless shall remain in full force and effect and the offending provision shall be stricken. The Court or other authorized body finding such provision unconstitutional, illegal or unenforceable shall construe this Agreement without such provision to give effect to the maximum extent possible the intentions of the Parties.

G. **Integration, Amendment and Waiver.** Except as otherwise set forth herein, this Agreement constitutes the entire agreement between the Parties on the matter of the Project. There are no understandings, agreements, or representations, oral or written, not specified herein regarding this Agreement. No waiver, consent, modification or change of terms of this Agreement shall bind either Party unless in writing and signed by both Parties and all necessary approvals have been obtained. Such waiver, consent, modification or change, if made, shall be effective only in the specific instance

and for the specific purpose given. The failure of either Party to enforce any provision of this Agreement shall not constitute a waiver by such Party of that or any other provision.

H. **Interpretation.** The titles of the sections of this Agreement are inserted for convenience of reference only and shall be disregarded in construing or interpreting any of its provisions.

I. **Independent Contractor.** Each of the Parties hereto shall be deemed an independent contractor for purposes of this Agreement. No representative, agent, employee or contractor of one Party shall be deemed to be a representative, agent, employee or contractor of the other Party for any purpose, except to the extent specifically provided herein. Nothing herein is intended, nor shall it be construed, to create between the Parties any relationship of principal and agent, partnership, joint venture or any similar relationship, and each Party hereby specifically disclaims any such relationship.

J. **No Third-Party Beneficiary.** Multnomah and Clackamas are the only parties to this Agreement and are the only parties entitled to enforce its terms. Nothing in this Agreement gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly, indirectly or otherwise, to third persons unless such third persons are individually identified by name herein and expressly described as intended beneficiaries of the terms of this Agreement.

K. **Subcontract and Assignment.** Multnomah shall not enter into any subcontracts for any of the work required by this Agreement, or assign or transfer any of its interest in this Agreement by operation of law or otherwise, without obtaining prior written approval from Clackamas, which shall be granted or denied in Clackamas' sole and absolute discretion. Clackamas' consent to any subcontract shall not relieve Agency of any of its duties or obligations under this Agreement.

L. **Counterparts.** This Agreement may be executed in several counterparts (electronic or otherwise), each of which shall be an original, all of which shall constitute the same instrument.

M. **Survival.** All provisions in sections 6, 8, and 9 shall survive the termination of this Agreement, together with all other rights and obligations herein which by their context are intended to survive.

N. **Necessary Acts.** Each Party shall execute and deliver to the others all such further instruments and documents as may be reasonably necessary to carry out this Agreement.

O. **Successors in Interest.** The provisions of this Agreement shall be binding upon and shall inure to the benefit of the parties hereto, and their respective authorized successors and assigns.

P. **Force Majeure.** Neither Multnomah nor Clackamas shall be held responsible for delay or default caused by events outside of Multnomah or Clackamas' reasonable control including, but not limited to, fire, terrorism, riot, acts of God, or war.

Q. **Attorney Fees.** In the event any arbitration, action, or proceeding, including any bankruptcy proceeding, is instituted to enforce any term of this Agreement, each party shall be responsible for its own attorneys' fees and expenses.

This Agreement consists of ten (10) sections plus the following exhibits that by this reference are incorporated herein:

☒ Exhibit A – Scope of Work

☒ Exhibit B – Compensation

☒ Exhibit C – Business Associate Agreement

[Signatures on Following Page]

SIGNATURE PAGE

IN WITNESS HEREOF, the Parties have executed this Agreement by the date set forth opposite their names below.

MULTNOMAH COUNTY

11/12/2021
Authorized Signature Date

Ebony Clarke, Director, Health Department
Name / Title (Printed)

CLACKAMAS COUNTY
BOARD OF COMMISSIONERS

Commissioner: Tootie Smith, Chair
Commissioner: Sonya Fischer
Commissioner: Paul Savas
Commissioner: Martha Schrader
Commissioner: Mark Shull

Signing on behalf of the Board:

Tootie Smith, Chair Date

Approved as to form:

Kathleen Rastetter via email May 17, 2021
County Counsel Date

EXHIBIT A
SCOPE OF WORK

Multnomah shall provide psychiatric consultation and expert opinion on cases involving Non-Medicaid clients receiving care coordination services through Clackamas County BHD, provide guidance to Mental Health Abuse Investigators and crisis and safety net programs as needed.

Multnomah's Consulting Psychiatrist shall perform the following work:

1. Provide adult, child, and adolescent psychiatric consultation services within the scope of their license for appropriate referrals. The Consulting Psychiatrist shall provide direction, consultation, and psychiatric review via telephone, teleconferencing, email, fax, face-to-face, in group and/or individual settings, to care coordinators.

2. Participate in clinical meetings or conference calls as needed with teams to discuss cases, and answer general questions, including questions related to medications.

3. Provide guidance to Clackamas' Mental Health Abuse Investigators to determine if medications and/or treatment options substantiate abuse.

4. Comply with the obligations set forth in the Business Associate Agreement, **Exhibit C** of this Agreement, and under HIPAA.

EXHIBIT B
COMPENSATION

a. Payment for all Work performed under this Agreement shall not exceed the total maximum sum of **$14,700.00**.

   Multnomah shall be compensated at the rate of **$195.00 per hour** in quarter hour increments for services rendered.

b. Multnomah shall submit **itemized monthly invoices by the 10th day of the month** following the month Services were provided. The invoice shall include:

   Contract **#10122**,
   Service details,
   Date(s) of service,
   Total amount due for all Services provided during the month, and
   Total amount billed to date by Multnomah prior to the current invoice.

   If Multnomah fails to present invoices in proper form within sixty (60) calendar days after the end of the month in which the services were rendered, Multnomah waives any rights to present such invoice thereafter and to receive payment therefor.

   All invoices and supporting documentation shall be sent by email or mail to:

   BHAP@clackamas.us and MTamargo@clackamas.us

   Clackamas County Behavioral Health Division
   Accounts Payable
   2051 Kaen Road, Suite #154
   Oregon City, Oregon 97045

   When submitting electronically, designate Multnomah County and Agreement **#10122** in the subject of the email.

c. Payments shall be made to Multnomah, within thirty (30) days, following Clackamas' review and approval of invoices submitted by Multnomah. Multnomah shall not submit invoices for, and Clackamas will not pay, any amount in excess of the maximum compensation amount set forth above. If this maximum compensation amount is increased by amendment of this Agreement, the amendment must be fully effective before Multnomah performs Work subject to the amendment.

EXHIBIT C
BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement is entered into upon signature ("Effective Date") by and between **Clackamas County, a political subdivision of the State of Oregon, on behalf of its Health, Housing and Human Services, Behavioral Health Division** ("Covered Entity") and **Multnomah County** ("Business Associate") in conformance with the Health Insurance Portability and Accountability Act of 1996, and its regulations ("HIPAA").

RECITALS

Whereas, the Covered Entity has engaged the services of the Business Associate, as defined under 45 CFR §160.103, for or on behalf of the Covered Entity;

Whereas, the Covered Entity may wish to disclose Individually Identifiable Health Information to the Business Associate in the performance of services for or on behalf of the Covered Entity as described in a Services Agreement ("Agreement");

Whereas, such information may be Protected Health Information ("PHI") as defined by the HIPAA Rules promulgated in accordance with the Administrative Simplification provisions of HIPAA;

Whereas, the Parties agree to establish safeguards for the protection of such information;

Whereas, the Covered Entity and Business Associate desire to enter into this Business Associate Agreement to address certain requirements under the HIPAA Rules;

Now, Therefore, the parties hereby agree as follows:

SECTION I – DEFINITIONS

1.1 "Breach" is defined as any unauthorized acquisition, access, use or disclosure of Unsecured PHI, unless the Covered Entity demonstrates that there is a low probability that the PHI has been compromised. The definition of Breach excludes the following uses and disclosures:

- 1.1.1 Unintentional access by a Covered Entity or Business Associate in good faith and within an Workforce member's course and scope of employment or placement;
- 1.1.2 Inadvertent one time disclosure between Covered Entity or Business Associate Work force members; and
- 1.1.3 The Covered Entity or Business Associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain the information.

1.2 "Covered Entity" shall have the meaning given to such term under the HIPAA Rules, including, but not limited to, 45 CFR §160.103.

1.3 "Designated Record Set" shall have the meaning given to such term under the HIPAA Rules, including, but not limited to 45 CFR §164.501.

1.4 "Effective Date" shall be the Effective Date of this Business Associate Agreement.

1.5 "Electronic Protected Health Information" or "Electronic PHI" shall have the meaning given to such term at 45 CFR §160.103, limited to information of the Covered Entity that the Business Associate creates, receives, accesses, maintains or transmits in electronic media on behalf of the Covered Entity under the terms and conditions of this Business Associate Agreement.

1.6 "Health Care Operations" shall have the meaning given to such term under the HIPAA Rules, including, but not limited to, 45 CFR §164.501.

1.7 "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules codified at 45 CFR Part 160 and Part 164.

1.8 "Individual" shall have the meaning given to such term in 45 CFR §160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR §164.502(g).

1.9 "Individually Identifiable Health Information" shall have the meaning given to such term under the HIPAA Rules, including, but not limited to 45 CFR §160.103.

1.10 "Protected Health Information" or "PHI" means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an Individual; the provision of health care to an Individual; or the past, present or future payment for the provision of health care to an Individual; and (ii) that identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual, and shall have the meaning given to such term under the HIPAA Rules, 45 CFR §160.103 and §164.501.

1.11 "Protected Information" shall mean PHI provided by the Covered Entity to Business Associate or created, maintained, transmitted or received by Business Associate on Covered Entity's behalf.

1.12 "Required by Law" shall have the meaning given to such phrase in 45 CFR §164.103.

1.13 "Secretary" shall mean the Secretary of the Department of Health and Human Services or his or her designee.

1.14 "Security Incident" shall have the meaning given to such phrase in 45 CFR §164.304.

1.15 "Unsecured Protected Health Information" shall mean protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in accordance with 45 CFR §164.402.

1.16 Workforce means employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a Covered Entity or Business Associate, is under the direct control of such Covered Entity or Business Associate, whether or not they are paid by the Covered Entity or Business Associate.

SECTION II – OBLIGATIONS AND ACTIVITIES OF THE BUSINESS ASSOCIATE

The Business Associate agrees to the following:

2.1 Not to use or further disclose PHI other than as permitted or required by this Business Associate Agreement or as Required by Law;

2.2 To use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to Electronic PHI, to prevent use or disclosure of PHI other than as provided for by this Business Associate Agreement;

2.3 To mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of a use or disclosure of PHI by the Business Associate in violation of the requirements of this Business Associate Agreement;

2.4 To immediately report to the Covered Entity any use or disclosure of PHI not provided for by this Business Associate Agreement of which it becomes aware, including any Security Incident of which it becomes aware;

2.5 In accordance with 45 CFR §§164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any agent, including a subcontractor, that creates, receives, maintains, or transmits PHI on behalf of the Business Associate agrees in writing to the same restrictions, conditions and requirements that apply to the Business Associate with respect to such PHI;

2.6 To provide access, at the request of the Covered Entity, and in the time and manner designated by the Covered Entity, to PHI in a Designated Record Set, to the Covered Entity or, as directed by the Covered Entity, to the Individual or the Individual's designee as necessary to meet the Covered Entity's obligations under 45 CFR §164.524; provided, however, that this Section 2.6 is applicable only to the extent the Designated Record Set is maintained by the Business Associate for the Covered Entity;

2.7 To make any amendment(s) to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR §164.526 at the request of the Covered Entity or an Individual, and in the time and manner designated by the Covered Entity; provided, however, that this Section 2.7 is applicable only to the extent the Designated Record Set is maintained by the Business Associate for the Covered Entity;

2.8 To make internal practices, books and records, including policies and procedures on PHI, relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of, the Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary's determining the Covered Entity's and the Business Associate's compliance with the HIPAA Rules;

2.9 To document such disclosures of PHI and information related to such disclosures as would be required for the Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528;

2.10 To provide to the Covered Entity or an Individual, in a time and manner designated by the Covered Entity, information collected in accordance with Section 2.9 of this Business Associate Agreement, to permit the Covered Entity to respond to a request by an accounting of disclosures of PHI in accordance with 45 CFR §164.528;

2.11 That if it creates, receives, maintains, or transmits any Electronic PHI on behalf of the Covered Entity, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. The Business Associate will report to the Covered Entity any Security Incident of which it becomes aware;

2.12 To retain records related to the PHI hereunder for a period of six (6) years unless the Business Associate Agreement is terminated prior thereto. In the event of termination of this Business Associate Agreement, the provisions of Section V of this Business Associate Agreement shall govern record retention, return or destruction;

2.13 To promptly notify the Covered Entity of a Breach of Unsecured PHI as soon as practicable, but in no case later than 10 calendar days, after the discovery of such Breach in accordance with 45 CFR §164.410. A Breach shall be treated as discovered as of the first day on which such Breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the Breach, who is an employee, officer, or agent of Business Associate. The notification shall include, to the extent possible, the identification of each Individual whose Unsecured PHI has been, or is reasonably believed by Business Associate to have been, accessed, acquired, used, or disclosed during the Breach in addition to the information required in Section V. In addition, Business Associate shall provide the Covered Entity with any other available information that the Covered Entity is required to include in the notification to the individual under 45 CFR §164.404(c); and

2.14 To the extent Business Associate is to carry out one or more of the Covered Entity's obligations under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the Covered Entity in the performance of such obligations.

SECTION III – THE PARTIES AGREE TO THE FOLLOWING PERMITTED USES AND DISCLOSURES BY THE BUSINESS ASSOCIATE:

3.1 Business Associate agrees to make uses and disclosures and requests for PHI consistent with the Covered Entity's minimum necessary policies and procedures.

3.2 Except as otherwise limited in this Business Associate Agreement, the Business Associate may use or disclose PHI to perform functions, activities or services for, or on behalf of, the Covered Entity as

specified in the Services Agreement, provided that such use or disclosure would not violate the HIPAA Rules if done by the Covered Entity; and,

3.3 Except as otherwise limited in this Business Associate Agreement, the Business Associate may:

a. **Use for management and administration**. Use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate; and,

b. **Disclose for management and administration**. Disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that disclosures are Required by Law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as Required by Law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

SECTION IV – NOTICE OF PRIVACY PRACTICES

4.1 If requested, the Covered Entity shall provide the Business Associate with the notice of privacy practices that the Covered Entity produces in accordance with 45 CFR §164.520, as well as any changes to such notice. Covered Entity shall (a) provide the Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect the Business Associate's permitted or required uses and disclosures; (b) notify the Business Associate of any restriction to the use or disclosure of PHI that the Covered Entity has agreed to in accordance with 45 CFR §164.522, to the extent that such restrictions may affect the Business Associate's use or disclosure of PHI; and (c) not request the Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Standards if done by the Covered Entity, except as set forth in Section 3.2 above.

SECTION V – BREACH NOTIFICATION REQUIREMENTS

5.1 With respect to any Breach, the Covered Entity shall notify each individual whose Unsecured PHI has been, or is reasonably believed by the Covered Entity to have been, accessed, acquired, used, or disclosed as a result of such Breach, except when law enforcement requires a delay pursuant to 45 CFR §164.412. This notice shall be:

a. Without unreasonable delay and in no case later than 60 calendar days after discovery of a Breach.

b. In plain language including and to the extent possible:

1) A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;

2) A description of the types of Unsecured PHI that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

3) Any steps Individuals should take to protect themselves from potential harm resulting from the Breach;

4) A brief description of what the Covered Entity and/or Business Associate is doing to investigate the Breach, to mitigate harm to Individuals, and to protect against any further Breaches; and,

5) Contact procedures for Individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, web site, or postal address.

c. By a method of notification that meets the requirements of 45 CFR §164.404(d).

d. Provided to the media when required under 45 CFR §164.406 and to the Secretary pursuant to 45 CFR §164.408.

5.2. Business Associate shall promptly provide any information requested by Covered Entity to provide the information described in Section 5.1.

SECTION VI – TERM AND TERMINATION

6.1 **Term**. The term of this Business Associate Agreement shall be effective as of the date set forth above in the first paragraph and shall terminate when all of the PHI created, maintained, transmitted or received by the Business Associate on behalf of the Covered Entity, is destroyed or returned to the Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.

6.2 **Termination for Cause**. Upon the Covered Entity's knowledge of a material breach of this Business Associate Agreement by the Business Associate, the Covered Entity shall provide an opportunity for the Business Associate to cure the breach or end the violation. The Covered Entity shall terminate this Business Associate Agreement and the Services Agreement if the Business Associate does not cure the breach or end the violation within the time specified by the Covered Entity, or immediately terminate this Business Associate Agreement if cure is not reasonably possible.

If the Business Associate fails to cure a breach for which cure is reasonably possible, the Covered Entity may take action to cure the breach, including but not limited to obtaining an injunction that will prevent further improper use or disclosure of PHI. Should such action be taken, the Business Associate agrees to indemnify the Covered Entity for any costs, including court costs and attorneys' fees, associated with curing the breach.

Upon the Business Associate's knowledge of a material breach of this Business Associate Agreement by the Covered Entity, the Business Associate shall provide an opportunity for the Covered Entity to cure the breach or end the violation. The Business Associate shall terminate this Business Associate Agreement and the Services Agreement if the Covered Entity does not cure the breach or end the violation within the time specified by the Business Associate, or immediately terminate this Business Associate Agreement if the Covered Entity has breached a material term of this Business Associate Agreement if cure is not reasonably possible.

6.3 **Effect of Termination**.

a. **Return or Destruction of PHI**. Except as provided in Section 6.3(b), upon termination of this Business Associate Agreement, for any reason, the Business Associate shall return, or if agreed to by the Covered Entity, destroy all PHI received from the Covered Entity, or created, maintained or received by the Business Associate on behalf of the Covered Entity and retain no copies. This provision shall apply to PHI that is in the possession of subcontractors or agents of the Business Associate.

b. **Return or Destruction of PHI Infeasible**. In the event that the Business Associate determines that returning or destroying PHI is infeasible, the Business Associate shall provide to the Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the parties that return or destruction of the PHI is infeasible, the Business Associate shall extend the protections of this Business Associate Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as the Business Associate maintains such PHI. In addition, the Business Associate shall continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to Electronic PHI to prevent use or disclosure of the PHI, for as long as the Business Associate retains the PHI.

SECTION VII – GENERAL PROVISIONS

7.1 **Regulatory references**. A reference in this Business Associate Agreement to the HIPAA Rules or a section in the HIPAA Rules means that Rule or Section as in effect or as amended from time to time.

7.2 **Compliance with law**. In connection with its performance under this Business Associate Agreement, Business Associate shall comply with all applicable laws, including but not limited to laws protecting the privacy of personal information about Individuals.

7.3 **Amendment**. The Parties agree to take such action as is necessary to amend this Business Associate Agreement from time to time. All amendments must be in writing and signed by both Parties.

7.4 **Indemnification by Business Associate**. Business Associate agrees to indemnify, defend and hold harmless the Covered Entity and its commissioners, employees, directors, officers, subcontractors, agents or other members of its workforce, each of the foregoing hereinafter referred to as "Indemnified Party," against all actual and direct losses suffered by the Indemnified Party and all liability to third parties arising from or in connection with Business Associate's breach of Sections II and III of this Business Associate Agreement. Accordingly, on demand, Business Associate shall reimburse any Indemnified Party for any and all actual and direct losses, liabilities, fines, penalties, costs or expenses (including reasonable attorneys' fees) which may for any reason be imposed upon any Indemnified Party by reason of any suit, claim, action, proceeding or demand by any third party which results for Business Associate's breach hereunder. The obligation to indemnify any Indemnified Party shall survive the expiration or termination of this Agreement for any reason.

7.5 **Survival**. The respective rights and obligations of Business Associate under Section II of this Business Associate Agreement shall survive the termination of the Services Agreement and this Business Associate Agreement.

7.6 **Interpretation**. Any ambiguity in this Business Associate Agreement shall be resolved to permit Covered Entity to comply with the HIPAA Rules.

[*Signature Page for BAA Follows*]

SIGNATURE PAGE FOR BUSINESS ASSOCIATE AGREEMENT

The Parties hereto have duly executed this Agreement as of the Effective Date as defined here above.

Business Associate	**Covered Entity**
MULTNOMAH COUNTY	**CLACKAMAS COUNTY**
Authorized Signature Date	Tootie Smith, Chair Date Board of Commissioners
Name / Title (Printed)	

Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

December 2, 2021

Board of Commissioners
Clackamas County

Members of the Board:

Approval of a Contract with Lines for Life for Crisis and Support Line Services.
Maximum Contract value of $389,967.00 provided through the State of Oregon, Oregon Health Plan funds.
No County General Funds are involved.

Purpose/Outcomes	Provides Afterhours Crisis and Support Telephone Line Services to adults in Clackamas County.
Dollar Amount and Fiscal Impact	Maximum contract value is **$389,967.** Year one value of $102,555.00; year two value of $141,384.00 and year three value of $146,028.00.
Funding Source	No County General Funds are involved. State of Oregon, Oregon Health Plan (OHP) funds are utilized.
Duration	This contract shall be in effect through June 30, 2024 with an option to extend for two additional one year periods.
Previous Board Action	Issues November 30, 2021
Strategic Plan Alignment	Ensuring safe, healthy and secure communities through the provision of mental health and substance use services.
Counsel Review	Reviewed and approved November 15, 2021 Andrew Naylor
Procurement Review	Was this item reviewed by Procurement? Yes
Contact Person	Mary Rumbaugh, Director – Behavioral Health Division – 503-742-5305
Agreement No.	County 4793, Behavioral Health 10332

BACKGROUND:
The Behavioral Health Division of the Health, Housing & Human Services Department requests the approval of a contract with Line for Life for afterhours behavioral health crisis line intervention and triage call coverage services.

PROCUREMENT PROCESS:
This project was advertised in accordance with ORS and LCRB Rules on May 19, 2021, through RFP 2021-11. Proposals were publicly opened on June 9, 2021. The County received two (2) Proposals in response to the RFP. After review of the Proposals, contracting with Lines for Life was determined to be in the best interest of the county based upon the scoring criteria outlined in RFP 2021-11.

RECOMMENDATION:
Staff recommends approval of this Contract.

Respectfully submitted,

Rodney Cook Type text here

Rodney A. Cook, Director
Health, Housing and Human Services

CLACKAMAS COUNTY
PERSONAL SERVICES CONTRACT
Contract #4793 / Behavioral Health #10359

This Personal Services Contract (this "Contract") is entered into between **Lines For Life** ("Contractor"), and Clackamas County, a political subdivision of the State of Oregon ("County") on behalf of its Department of Health, Housing and Human Services (H3S), Behavioral Health Division.

ARTICLE I.

1. **Effective Date and Duration.** This Contract shall become effective upon signature of both parties. Unless earlier terminated or extended, this Contract shall expire on **June 30, 2024** with an option to renew for two (2) additional one-year terms upon the mutual written agreement of both parties.

2. **Scope of Work.** Contractor shall provide the following personal services: After Hours Telephone Crisis and Support Line Services ("Work"), the negotiated scope, which is based on Contractor's Response to Clackamas County RFP 2021-11, is set forth in **Exhibit A,** attached and incorporated by reference herein.

3. **Consideration.** The County agrees to pay Contractor on time and materials basis in accordance with the rates and costs specified in this Contract**.** The following table represent the maximum totals available for annual compensation under this Contract:

Year	Monthly Rate (200-300 calls)	Overage Rate (per call)	Annual Totals - Not to Exceed
Year One October 1, 2021 - June 30, 2022	$7,950.00	$26.50	$102,555.00
Year Two July 1, 2022 - June 30, 2023	$8,220.00	$27.40	$141,384.00
Year Three July 1, 2023 - June 30, 2024	$8,490.00	$28.30	$146,028.00
Year Four July 1, 2024 - June 30, 2025	To be negotiated if option to extend is exercised		
Year Five July 1, 2025 - June 30, 2026	To be negotiated if option to extend is exercised		

If any interim payments to Contractor are made, such payments shall be made only in accordance with the schedule and requirements in Exhibit B.

For years one through three of this Contract, the County agrees to pay Contractor, from available and authorized funds, a sum not to exceed **Three Hundred Eighty-Nine Thousand Nine Hundred Sixty-Seven Dollars ($389,967),** for accomplishing the Work required by this Contract.

4. **Invoices and Payments.** Unless otherwise specified, Contractor shall submit monthly invoices for Work performed. Invoices shall describe all Work performed with particularity, by whom it was performed, and shall itemize and explain all expenses for which reimbursement is claimed. The invoices shall include the total amount billed to date by Contractor prior to the current invoice. If Contractor fails to present invoices in proper form within sixty (60) calendar days after the end of the

month in which the services were rendered, Contractor waives any rights to present such invoice thereafter and to receive payment therefor. Payments shall be made in accordance with ORS 293.462 to Contractor following the County's review and approval of invoices submitted by Contractor. Contractor shall not submit invoices for, and the County will not be obligated to pay, any amount in excess of the maximum compensation amount set forth above. If this maximum compensation amount is increased by amendment of this Contract, the amendment must be fully effective before Contractor performs Work subject to the amendment.

Invoices shall reference the above Contract Number and be submitted to: BHAP@clackamas.us

5. **Travel and Other Expense.** Authorized: ☐ Yes ☒ No
If travel expense reimbursement is authorized in this Contract, such expense shall only be reimbursed at the rates in the County Contractor Travel Reimbursement Policy, hereby incorporated by reference and found at: https://www.clackamas.us/finance/terms.html.Travel expense reimbursement is not in excess of the not to exceed consideration.

6. **Contract Documents.** This Contract consists of the following documents, which are listed in descending order of precedence and are attached and incorporated by reference, this Contract, Exhibit A, Exhibit B, Exhibit C, Exhibit D and Exhibit E.

7. **Contractor and County Contacts.**

Contractor Administrator: David Westbrook Phone: 503-267-7065 Email: davidw@linesforlife.org	County Administrator: Angela Brink Phone: 503-522-2396 Email: abrink@clackamas.us and BHContracts@clackamas.us

Payment information will be reported to the Internal Revenue Service ("IRS") under the name and taxpayer ID number submitted. (See I.R.S. 1099 for additional instructions regarding taxpayer ID numbers.) Information not matching IRS records will subject Contractor payments to backup withholding.

ARTICLE II.

1. **ACCESS TO RECORDS.** Contractor shall maintain books, records, documents, and other evidence, in accordance with generally accepted accounting procedures and practices, sufficient to reflect properly all costs of whatever nature claimed to have been incurred and anticipated to be incurred in the performance of this Contract. County and their duly authorized representatives shall have access to the books, documents, papers, and records of Contractor, which are directly pertinent to this Contract for the purpose of making audit, examination, excerpts, and transcripts. Contractor shall maintain such books and records for a minimum of six (6) years, or such longer period as may be required by applicable law, following final payment and termination of this Contract, or until the conclusion of any audit, controversy or litigation arising out of or related to this Contract, whichever date is later.

2. **AVAILABILITY OF FUTURE FUNDS.** Any continuation or extension of this Contract after the end of the fiscal period in which it is written is contingent on a new appropriation for each succeeding fiscal period sufficient to continue to make payments under this Contract, as determined by the County in its sole administrative discretion.

3. **CAPTIONS.** The captions or headings in this Contract are for convenience only and in no way define, limit, or describe the scope or intent of any provisions of this Contract.

4. **COMPLIANCE WITH APPLICABLE LAW.** Contractor shall comply with all applicable federal, state and local laws, regulations, executive orders, and ordinances, as such may be amended from time to time.

5. **COUNTERPARTS.** This Contract may be executed in several counterparts (electronic or otherwise), each of which shall be an original, all of which shall constitute the same instrument.

6. **GOVERNING LAW.** This Contract, and all rights, obligations, and disputes arising out of it, shall be governed and construed in accordance with the laws of the State of Oregon and the ordinances of Clackamas County without regard to principles of conflicts of law. Any claim, action, or suit between County and Contractor that arises out of or relates to the performance of this Contract shall be brought and conducted solely and exclusively within the Circuit Court for Clackamas County, for the State of Oregon. Provided, however, that if any such claim, action, or suit may be brought in a federal forum, it shall be brought and conducted solely and exclusively within the United States District Court for the District of Oregon. In no event shall this section be construed as a waiver by the County of any form of defense or immunity, whether sovereign immunity, governmental immunity, immunity based on the Eleventh Amendment to the Constitution of the United States or otherwise, from any claim or from the jurisdiction of any court. Contractor, by execution of this Contract, hereby consents to the personal jurisdiction of the courts referenced in this section.

7. **RESPONSIBILITY FOR DAMAGES; INDEMNITY.** Contractor shall be responsible for all damage to property, injury to persons, and loss, expense, inconvenience, and delay which may be caused by, or result from, the conduct of Work, or from any act, omission, or neglect of Contractor, its subcontractors, agents, or employees. The Contractor agrees to indemnify, hold harmless and defend the County, and its officers, elected officials, agents and employees from and against all claims and actions, and all expenses incidental to the investigation and defense thereof, arising out of or based upon damage or injuries to persons or property caused by the errors, omissions, fault or negligence of the Contractor or the Contractor's employees, subcontractors, or agents. However, neither Contractor nor any attorney engaged by Contractor shall defend the claim in the name of County or any department of County, nor purport to act as legal representative of County or any of its departments, without first receiving from the Clackamas County Counsel's Office authority to act as legal counsel for County, nor shall Contractor settle any claim on behalf of County without the approval of the Clackamas County Counsel's Office. County may, at its election and expense, assume its own defense and settlement.

8. **INDEPENDENT CONTRACTOR STATUS.** The service(s) to be rendered under this Contract are those of an independent contractor. Although the County reserves the right to determine (and modify) the delivery schedule for the Work to be performed and to evaluate the quality of the completed performance, County cannot and will not control the means or manner of Contractor's performance. Contractor is responsible for determining the appropriate means and manner of performing the Work. Contractor is not to be considered an agent or employee of County for any purpose, including, but not limited to: (A) The Contractor will be solely responsible for payment of any Federal or State taxes required as a result of this Contract; and (B) This Contract is not intended to entitle the Contractor to any benefits generally granted to County employees, including, but not limited to, vacation, holiday and sick leave, other leaves with pay, tenure, medical and dental coverage, life and disability insurance, overtime, Social Security, Workers' Compensation, unemployment compensation, or retirement benefits.

9. **INSURANCE.** Contractor shall secure at its own expense and keep in effect during the term of the performance under this Contract the insurance required and minimum coverage detailed in **Exhibit C.**

10. **LIMITATION OF LIABILITIES.** This Contract is expressly subject to the debt limitation of Oregon counties set forth in Article XI, Section 10, of the Oregon Constitution, and is contingent upon funds being appropriated therefore. Any provisions herein which would conflict with law are deemed inoperative to that extent. Except for liability arising under or related to Article II, Section 13 or Section 20 neither party shall be liable for (i) any indirect, incidental, consequential or special damages under this Contract or (ii) any damages of any sort arising solely from the termination of this Contact in accordance with its terms.

11. **NOTICES.** Except as otherwise provided in this Contract, any required notices between the parties shall be given in writing by personal delivery, email, or mailing the same, to the Contract Administrators identified in Article 1, Section 6. If notice is sent to County, a copy shall also be sent to: Clackamas County Procurement, 2051 Kaen Road, Oregon City, OR 97045, or procurement@clackamas.us. Any communication or notice so addressed and mailed shall be deemed to be given five (5) days after mailing, and immediately upon personal delivery, or within 2 hours after the email is sent during County's normal business hours (Monday – Thursday, 7:00 a.m. to 6:00 p.m.) (as recorded on the device from which the sender sent the email), unless the sender receives an automated message or other indication that the email has not been delivered.

12. **OWNERSHIP OF WORK PRODUCT.** All work product of Contractor that results from this Contract (the "Work Product") is the exclusive property of County. County and Contractor intend that such Work Product be deemed "work made for hire" of which County shall be deemed the author. If for any reason the Work Product is not deemed "work made for hire," Contractor hereby irrevocably assigns to County all of its right, title, and interest in and to any and all of the Work Product, whether arising from copyright, patent, trademark or trade secret, or any other state or federal intellectual property law or doctrine. Contractor shall execute such further documents and instruments as County may reasonably request in order to fully vest such rights in County. Contractor forever waives any and all rights relating to the Work Product, including without limitation, any and all rights arising under 17 USC § 106A or any other rights of identification of authorship or rights of approval, restriction or limitation on use or subsequent modifications. Notwithstanding the above, County shall have no rights in any pre-existing Contractor intellectual property provided to County by Contractor in the performance of this Contract except to copy, use and re-use any such Contractor intellectual property for County use only.

13. **REPRESENTATIONS AND WARRANTIES.** Contractor represents and warrants to County that (A) Contractor has the power and authority to enter into and perform this Contract; (B) this Contract, when executed and delivered, shall be a valid and binding obligation of Contractor enforceable in accordance with its terms; (C) Contractor shall at all times during the term of this Contract, be qualified, professionally competent, and duly licensed to perform the Work; (D) Contractor is an independent contractor as defined in ORS 670.600; and (E) the Work under this Contract shall be performed in a good and workmanlike manner and in accordance with the highest professional standards. The warranties set forth in this section are in addition to, and not in lieu of, any other warranties provided.

14. **SURVIVAL.** All rights and obligations shall cease upon termination or expiration of this Contract, except for the rights and obligations set forth in Article II, Sections 1, 6, 7, 10, 12, 13, 14, 15, 17, 20, 21, 25, 27, 28, 30, and 32 and all other rights and obligations which by their context are intended to survive. However, such expiration shall not extinguish or prejudice the County's right to enforce this Contract with respect to: (a) any breach of a Contractor warranty; or (b) any default or defect in Contractor performance that has not been cured.

15. **SEVERABILITY.** If any term or provision of this Contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and provisions

shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the Contract did not contain the particular term or provision held to be invalid.

16. **SUBCONTRACTS AND ASSIGNMENTS.** Contractor shall not enter into any subcontracts for any of the Work required by this Contract, or assign or transfer any of its interest in this Contract by operation of law or otherwise, without obtaining prior written approval from the County, which shall be granted or denied in the County's sole discretion. In addition to any provisions the County may require, Contractor shall include in any permitted subcontract under this Contract a requirement that the subcontractor be bound by this Article II, Sections 1, 7, 8, 13, 16 and 27 as if the subcontractor were the Contractor. County's consent to any subcontract shall not relieve Contractor of any of its duties or obligations under this Contract.

17. **SUCCESSORS IN INTEREST.** The provisions of this Contract shall be binding upon and shall inure to the benefit of the parties hereto, and their respective authorized successors and assigns.

18. **TAX COMPLIANCE CERTIFICATION.** The Contractor shall comply with all federal, state and local laws, regulation, executive orders and ordinances applicable to this Contract. Contractor represents and warrants that it has complied, and will continue to comply throughout the duration of this Contract and any extensions, with all tax laws of this state or any political subdivision of this state, including but not limited to ORS 305.620 and ORS chapters 316, 317, and 318. Any violation of this section shall constitute a material breach of this Contract and shall entitle County to terminate this Contract, to pursue and recover any and all damages that arise from the breach and the termination of this Contract, and to pursue any or all of the remedies available under this Contract or applicable law.

19. **TERMINATIONS.** This Contract may be terminated for the following reasons: (A) by mutual agreement of the parties or by the County (i) for convenience upon thirty (30) days written notice to Contractor, or (ii) at any time the County fails to receive funding, appropriations, or other expenditure authority as solely determined by the County; or (B) if contractor breaches any Contract provision or is declared insolvent, County may terminate after thirty (30) days written notice with an opportunity to cure. Provided, however, that Contractor's failure to meet certain performance standards shall be subject to the corrective action process described in Exhibit A.

    Upon receipt of written notice of termination from the County, Contractor shall immediately stop performance of the Work. Upon termination of this Contract, Contractor shall deliver to County all documents, Work Product, information, works-in-progress and other property that are or would be deliverables had the Contract Work been completed. Upon County's request, Contractor shall surrender to anyone County designates, all documents, research, objects or other tangible things needed to complete the Work.

20. **REMEDIES.** If terminated by the County due to a breach by the Contractor, then the County shall have any remedy available to it in law or equity. If this Contract is terminated for any other reason, Contractor's sole remedy is payment for the goods and services delivered and accepted by the County, less any setoff to which the County is entitled.

21. **NO THIRD PARTY BENEFICIARIES.** County and Contractor are the only parties to this Contract and are the only parties entitled to enforce its terms. Nothing in this Contract gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly, indirectly or otherwise, to third persons unless such third persons are individually identified by name herein and expressly described as intended beneficiaries of the terms of this Contract.

22. **TIME IS OF THE ESSENCE.** Contractor agrees that time is of the essence in the performance this Contract.

23. **FOREIGN CONTRACTOR.** If the Contractor is not domiciled in or registered to do business in the State of Oregon, Contractor shall promptly provide to the Oregon Department of Revenue and the Secretary of State, Corporate Division, all information required by those agencies relative to this Contract. The Contractor shall demonstrate its legal capacity to perform these services in the State of Oregon prior to entering into this Contract.

24. **FORCE MAJEURE.** Neither County nor Contractor shall be held responsible for delay or default caused by events outside the County or Contractor's reasonable control including, but not limited to, fire, terrorism, riot, acts of God, or war. However, Contractor shall make all reasonable efforts to remove or eliminate such a cause of delay or default and shall upon the cessation of the cause, diligently pursue performance of its obligations under this Contract.

25. **WAIVER.** The failure of County to enforce any provision of this Contract shall not constitute a waiver by County of that or any other provision.

26. **PUBLIC CONTRACTING REQUIREMENTS.** Pursuant to the public contracting requirements contained in Oregon Revised Statutes ("ORS") Chapter 279B.220 through 279B.235, Contractor shall:
    a. Make payments promptly, as due, to all persons supplying to Contractor labor or materials for the prosecution of the work provided for in the Contract.
    b. Pay all contributions or amounts due the Industrial Accident Fund from such Contractor or subcontractor incurred in the performance of the Contract.
    c. Not permit any lien or claim to be filed or prosecuted against County on account of any labor or material furnished.
    d. Pay the Department of Revenue all sums withheld from employees pursuant to ORS 316.167.
    e. As applicable, the Contractor shall pay employees for work in accordance with ORS 279B.235, which is incorporated herein by this reference. The Contractor shall comply with the prohibitions set forth in ORS 652.220, compliance of which is a material element of this Contract, and failure to comply is a breach entitling County to terminate this Contract for cause.
    f. If the Work involves lawn and landscape maintenance, Contractor shall salvage, recycle, compost, or mulch yard waste material at an approved site, if feasible and cost effective.

27. **NO ATTORNEY FEES**. In the event any arbitration, action or proceeding, including any bankruptcy proceeding, is instituted to enforce any term of this Contract, each party shall be responsible for its own attorneys' fees and expenses.

28. **CONFIDENTIALITY.** Contractor acknowledges that it and its employees and agents may, in the course of performing their obligations under this Contract, be exposed to or acquire information that the County desires or is required to maintain as confidential. Any and all information of any form obtained by Contractor or its employees or agents in the performance of this Contract, including but not limited to Personal Information (as "Personal Information" is defined in ORS 646A.602(11), shall be deemed to be confidential information of the County ("Confidential Information"). Any reports or other documents or items (including software) which result from the use of the Confidential Information by Contractor shall be treated with respect to confidentiality in the same manner as the Confidential Information.

    Contractor agrees to hold Confidential Information in strict confidence, using at least the same degree of care that Contractor uses in maintaining the confidentiality of its own confidential information, and not to copy, reproduce, sell, assign, license, market, transfer or otherwise dispose of, give or disclose Confidential Information to third parties or use Confidential Information for any purposes whatsoever

(other than in the performance of this Contract), and to advise each of its employees and agents of their obligations to keep Confidential Information confidential.

Contractor agrees that, except as directed by the County, Contractor will not at any time during or after the term of this Contract, disclose, directly or indirectly, any Confidential Information to any person, and that upon termination or expiration of this Contract or the County's request, Contractor will turn over to the County all documents, papers, records and other materials in Contractor's possession which embody Confidential Information. Contractor acknowledges that breach of this Contract, including disclosure of any Confidential Information, or disclosure of other information that, at law or in good conscience or equity, ought to remain confidential, will give rise to irreparable injury to the County that cannot adequately be compensated in damages. Accordingly, the County may seek and obtain injunctive relief against the breach or threatened breach of the foregoing undertakings, in addition to any other legal remedies that may be available. Contractor acknowledges and agrees that the covenants contained herein are necessary for the protection of the legitimate business interests of the County and are reasonable in scope and content.

Contractor agrees to comply with all reasonable requests by the County to ensure the confidentiality and nondisclosure of the Confidential Information, including if requested and without limitation: (a) obtaining nondisclosure agreements, in a form approved by the County, from each of Contractor's employees and agents who are performing services, and providing copies of such agreements to the County; and (b) performing criminal background checks on each of Contractor's employees and agents who are performing services, and providing a copy of the results to the County.

Contractor shall report, either orally or in writing, to the County any use or disclosure of Confidential Information not authorized by this Contract or in writing by the County, including any reasonable belief that an unauthorized individual has accessed Confidential Information. Contractor shall make the report to the County immediately upon discovery of the unauthorized disclosure, but in no event more than two (2) business days after Contractor reasonably believes there has been such unauthorized use or disclosure. Contractor's report shall identify: (i) the nature of the unauthorized use or disclosure, (ii) the Confidential Information used or disclosed, (iii) who made the unauthorized use or received the unauthorized disclosure, (iv) what Contractor has done or shall do to mitigate any deleterious effect of the unauthorized use or disclosure, and (v) what corrective action Contractor has taken or shall take to prevent future similar unauthorized use or disclosure. Contractor shall provide such other information, including a written report, as reasonably requested by the County.

Notwithstanding any other provision in this Contract, Contractor will be responsible for all damages, fines and corrective action (including credit monitoring services) arising from disclosure of such Confidential Information caused by a breach of its data security or the confidentiality provisions hereunder.

The provisions in this Section shall operate in addition to, and not as limitation of, the confidentiality and similar requirements set forth in the rest of the Contract, as it may otherwise be amended. Contractor's obligations under this Contract shall survive the expiration or termination of the Contract, as amended, and shall be perpetual.

29. **CRIMINAL BACKGROUND CHECK REQUIREMENTS.** Contractor shall be required to have criminal background checks (and in certain instances fingerprint background checks) performed on all employees, agents, or subcontractors that perform services under this Contract. Only those employees, agents, or subcontractors that have met the acceptability standards of the County may perform services under this Contract or be given access to Personal Information, Confidential Information or access to County facilities.

30. **ABUSE REPORTING.** Contractor shall comply with all processes and procedures of child abuse (ORS 419B.005 – 419B.050), mentally ill and developmentally disabled abuse (ORS 430.731 – 430.768 and OAR 943-045-0250 through 493-045-0370) and elder abuse reporting laws (ORS 124.050 – 124.092) as if Contractor were a mandatory abuse reporter. If Contractor is not a mandatory reporter by statute, these reporting requirements shall apply during work hours only. Contractor shall immediately report to the proper State or law enforcement agency circumstances (and provide such other documentation as may be relevant) supporting reasonable cause to believe that any person has abused a child, mentally ill or developmentally disabled adult or an elderly person, or that any such person has been abused.

31. **FEDERAL CONTRACTING REQUIREMENTS**: Contractor shall comply with the federal terms and conditions in Exhibit D.

32. **MERGER.** THIS CONTRACT CONSTITUTES THE ENTIRE AGREEMENT BETWEEN THE PARTIES WITH RESPECT TO THE SUBJECT MATTER REFERENCED THEREIN. THERE ARE NO UNDERSTANDINGS, AGREEMENTS, OR REPRESENTATIONS, ORAL OR WRITTEN, NOT SPECIFIED HEREIN REGARDING THIS CONTRACT. NO AMENDMENT, CONSENT, OR WAIVER OF TERMS OF THIS CONTRACT SHALL BIND EITHER PARTY UNLESS IN WRITING AND SIGNED BY ALL PARTIES. ANY SUCH AMENDMENT, CONSENT, OR WAIVER SHALL BE EFFECTIVE ONLY IN THE SPECIFIC INSTANCE AND FOR THE SPECIFIC PURPOSE GIVEN. CONTRACTOR, BY THE SIGNATURE HERETO OF ITS AUTHORIZED REPRESENTATIVE, IS AN INDEPENDENT CONTRACTOR, ACKNOWLEDGES HAVING READ AND UNDERSTOOD THIS CONTRACT, AND CONTRACTOR AGREES TO BE BOUND BY ITS TERMS AND CONDITIONS.

By their signatures below, the parties to this Contract agree to the terms, conditions, and content expressed herein.

Lines For Life

David Westbrook Digitally signed by David Westbrook Date: 2021.11.12 15:49:11 -08'00'

Authorized Signature Date

David Westbrook

Name / Title (Printed)

126379-14

Oregon Business Registry #

DNP/OR

Entity Type / State of Formation

Clackamas County

Chair Date

Recording Secretary

APPROVED AS TO FORM

Andrew Naylor Digitally signed by Andrew Naylor Date: 2021.11.15 08:47:43 -08'00'

County Counsel Date

EXHIBIT A
PERSONAL SERVICES CONTRACT
SCOPE OF WORK

As the Oregon Alcohol and Other Drug Hotline and the Oregon Affiliate of the National Suicide Prevention Lifeline, accredited by the American Association of Suicidality, Contractor shall work collaboratively with County to provide behavioral health Crisis and Support Line intervention and triage call coverage services after hours, holidays, and weekends as described below.

A. Introduction

Contractor shall work collaboratively with the County to provide behavioral health after-hours telephone Crisis & Support Line services. These services will include crisis intervention, consultation, triage and referral according to standards outlined in OAR 309-019-0150 (1) and according to the protocols below. Contractor also shall address any future Scope of Work changes to meet the business needs of the County during the term of the Contract.

B. Contractor Staff

Contractor shall employ, train, and supervise master's degree level behavioral health staff or bachelor's degree level behavioral health staff with master's level in-house supervision to provide direct telephonic service to callers.

C. Contractor Staff Training

Contractor shall train their staff in accordance with the training requirements listed in OAR 309-019- 0315 for personnel working in a similar capacity as Clackamas County staff . Staff training curriculum shall include best practices for the following: Risk assessment, including suicide risk assessment; Suicide intervention and prevention; Safety planning; Lethal means counseling; De-escalation methods; Crisis intervention; Recovery support, including peer delivered services; Trauma informed care; and Cultural awareness.

Crisis and Support line staff shall also be trained in Motivational Interviewing, Applied Suicide Intervention Skills Training (ASIST), Stages of Change and elements of Dialectical Behavior Therapy (DBT) related to crisis intervention.

County shall train Contractor staff on appropriate Clackamas County resources including Clackamas County Behavioral Health Division (CCBHD) procedures. Contractor will also provide training to their staff regarding the contractual expectations of this contract.

D. Hours of Operation

County Crisis and Support Line shall be forwarded to Contractor by County staff per the following schedule:

Monday, Tuesday, Wednesday, Thursday: 6:30 p.m. through 8:45 a.m.
Friday: 6:30 p.m. through 10:30 a.m.
Saturday: 6:30 p.m. through 8:45 a.m. Monday **Sunday: Clackamas Mental Health Center CLOSED**

HOLIDAYS	CONTRACTOR HOURS	CENTER HOURS
Juneteenth, June 19	Midnight – 10:30 a.m.; 6:30 p.m. through 8:45 a.m. June 20	10a.m. – 7p.m.
Independence Day, July 4	Midnight – 10:30 a.m.; 3:30 p.m. through 8:45 a.m. July 5	11 a.m. – 4 p.m.
Labor Day, First Monday in September	Midnight – 10:30 a.m.; 6:30 p.m. through 8:45 a.m. Tuesday	10 a.m. – 7 p.m.
Veteran's Day, November 11	Midnight – 10:30 a.m.; 6:30 p.m. through 8:45 a.m. November 12	10 a.m. – 7 p.m.
Thanksgiving Day, Fourth Thursday in November	Midnight – 11:30 a.m.; 3:30 p.m. through 8:45 a.m. Friday	11 a.m. – 4 p.m.
Christmas Day, December 25	Midnight – 11:30 a.m.; 3:30 p.m. through 8:45 a.m. December 26	11 a.m. – 4 p.m.
New Year's Day, January 1	Midnight – 11:30 a.m.; 3:30 p.m. through 8:45 a.m. January 2	11 a.m. – 4 p.m.
MLK Day, Third Monday in January	Midnight – 10:30 a.m.; 6:30 p.m. through 8:45 a.m. Tuesday	10 a.m. – 7 p.m.
President's Day, Third Monday in February	Midnight – 10:30 a.m.; 6:30 p.m. through 8:45 a.m. Tuesday	10 a.m. – 7 p.m.
Memorial Day, Last Monday in May	Midnight – 10:30 a.m.; 6:30 p.m. through 8:45 a.m. Tuesday	10 a.m. – 7 p.m.

Upon notification from County, Contractor will allow County to forward the Crisis and Support Line to Contactor outside of the above scheduled times.

E. Procedures

1. Contractor staff shall answer all calls forwarded from the Clackamas County Crisis and Support Line (503) 655-8585 as follows: "Clackamas County Crisis and Support Line, this is (Contractor staff first name), how may I help you?"

2. Contractor shall utilize appropriate language interpreter services for non-English speaking callers.

3. Procedures shall be outlined in detail in the Clackamas County Afterhours Crisis Desk Manual for the following:

a. Collecting and documenting demographic information
b. Directing Police Officer Custodies
c. Clackamas County Juvenile Department Intake and Assessment Center (IAC)
d. Referrals to Clackamas Mental Health Center
e. Abuse Reporting
f. Callers from outside Clackamas County

g. Psychiatric Security Review Board (PSRB) Crises
h. Hospital Holds/Involuntary Commitment Program
i. Transport Custody Facilities
j. Alarms/facility issues reports

When there are programmatic or procedural changes or updates, County will provide new information by email, which Contractor will enter into the appropriate database. Contractor will alert line staff that to these changes.

4. Contractor's staff will immediately notify on-call County staff of all calls, which are emergent or urgent in nature and require intervention. If life threatening emergencies, the Contractor's staff will also initiate contact with local EMS and or law enforcement agencies specific to the area from where the person is calling.

5. Calls to 503-655-8585 from County staff reporting in sick: When County staff call in sick to this line, Contractor shall prompt them to contact their supervisor if coverage is an immediate concern and to leave a message at Clackamas Mental Health Center's main number, 503-722-6200.

6. On-call County administrator: When clinical or logistical issues arise that cannot be answered or resolved by Contractor's supervisory or Qualified Mental Health Professional (QMHP) staff, Contractor may contact the on-call administrator at 503-722-6263.

F. Complaint Process

Contractor must implement policies and procedures to document any potential complaints or grievances by callers. At a minimum, the policies and procedures shall include all steps from receipt of a complaint or grievance, through the investigation, and concluding with the notification of resolution to the grievant, if the grievant requests notification of the resolution.

Contractor will be required to resolve all complaints or grievances within thirty (30) calendar days and shall provide a copy of the processes and procedures to the County within the first (60) days after contract effective date.

All complaints/grievances and their respective resolutions shall be fully documented. Upon request by County, Contractor shall provide a copy of the documentation pertaining to a complaint/grievance.

G. Oversight

Contractor and County administrative staff shall meet at least quarterly to troubleshoot, problem solve, and refine protocols. Contractor shall participate in oversight reviews conducted by the County. Oversight may include, but is not limited to review of the Contractor's policies and procedures, staff training curriculum and grievance/complaint process.

H. Performance Requirements

Contractor shall maintain and report on the following performance standards:

a. Average wait time before system initially picks up a call to Clackamas County line: One minute or less
b. Average wait time before a live clinical staff picks up a call to Clackamas County line: Three minutes for less

When response time is outside these expectations **greater than 5%** of the time within a month, Contractor shall examine the reasons for this and report to the County proactively.

When response time is outside these expectations **greater than 10%** of the time within a month, County shall work with Contractor to develop a Corrective Action Plan. The Plan shall be reviewed three months following implementation. Review may extend the term of the Corrective Action Plan or deem the issue resolved and terminate the Plan.

If performance issues persist, County may pursue all rights and remedies available to it at law, in equity, or under this Contract.

EXHIBIT B
DEFINITIONS

Whenever used in this Contract, the following terms shall have the meanings set forth below:

Allowable Costs: Costs described in OMB Circular A-87 except to the extent such costs are limited or excluded by other provisions of this Contract.

AMH: State of Oregon, Department of Human Services, Addictions and Mental Health Division (now known as the Department of Human Services of the State of Oregon [DHS]).

CCO: Coordinated Care Organization is an entity that has been certified as meeting the criteria adopted by the Oregon Health Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care services.

Contractor: The entity contracted by the County.

County: Clackamas County Behavioral Health Division.

Covered Services: Medically appropriate services specified in OAR 410-141-3120, "Operations and Provision of Health Services" and limited in accordance with OAR 410-141-3420, "Billing and Payment" for OHP Members. The term "Covered Services" may be expanded, limited, or otherwise changed pursuant to the Clackamas County Health Share of Oregon/Clackamas Participation Agreement and OARs. Covered Services may also refer to authorized services provided to uninsured, indigent clients.

Department: DHS (formally AMH) contracts with County to establish and finance community mental health and addition programs; County, in turn, subcontracts certain services to Contractor.

DHS: the Department of Human Services of the State of Oregon (formerly known as the Addictions & Mental Health Division [AMH]).

Federal Funds: Funds paid to Contractor under this Contract that are received from an agency, instrumentality or program of the Federal government of the United States.

Health Share of Oregon: A Coordinated Care Organization (CCO) serving Oregon Health Plan enrollees of Clackamas, Multnomah, and Washington Counties.

Individual: An individual accessing publicly funded behavioral health services who is either an OHP Member or is determined eligible for services as an uninsured, indigent individual.

Medicaid: Federal funds received by OHA under the Title XIX of the Social Security Act and Children's Helath Insurance Program Funds administered jointly with Title XIX funds as part of the State medical assistance program by OHA.

Mental Health Services: Treatment services for individuals diagnosed with serious mental health illness, or other mental or emotional disturbance posing a danger to the health and safety of themselves or others.

Misexpenditure: Money, other than an overexpenditure disbursed to Contractor by County under this Contract and expended by Contractor that:

(a) is identified by the Federal government as expended contrary to applicable statutes, rules, OMB Circulars or any other authority that governs the permissible expenditure of such money, for which the Federal government has requested reimbursement by the State of Oregon and whether in the form

of a Federal determination of improper use of Federal funds, a Federal notice of disallowance, or otherwise; or

(b) is identified by the County, State of Oregon or OHA as expended in a manner other than that permitted by this Contract, including without limitation, any money expended by Contractor, contrary to applicable statutes, rules, OMB Circulars or any other authority that governs the permissible expenditure of such money; or

(c) is identified by the County, State of Oregon or OHA as expended on the delivery of a service that did not meet the standards and requirements of this Contract with respect to that service.

Measures and Outcomes Tracking System (MOTS): the DHS (formally AMH) data system that stores client data submitted by Contractor and/or County.

OAR: Oregon Administrative Rules duly promulgated by the Oregon Health Authority and as amended from time to time.

OHA: The State of Oregon, acting by and through its Oregon Health Authority.

OHP Member: An individual found eligible by a division of the Oregon Department of Human Services to receive services under the OHP (Oregon Health Plan) Medicaid Demonstration Project or State Children's Health Insurance Program and who is enrolled with County as Health Share of Oregon/Clackamas.

Oregon Web Infrastructure for Treatment Services (OWITS): Is 1) an optional free electronic health records system available to Counties and their Providers to submit the MOTS data, and 2) a system to manage the DSH (formally AMH) services.

Primary Source Verification: Verification from the original source of a specific credential (education, training, licensure) to determine the accuracy of the qualifications of an individual health care practitioner. Examples of primary source verification include, but are not limited to, direct correspondence, telephone verification and internet verifications.

Third Party Resources: Any individual, entity, or program that is, or may be, liable to pay all or part of the cost of any Covered Service furnished to an OHP Member, including but not limited to: private health insurance or group health plan; employment-related health insurance; medical support from absent parents; workers' compensation; Medicare; automobile liability insurance; other federal programs such as Veteran's Administration, Armed Forces Retirees and Dependent Act, Armed Forces Active Duty and Dependents Military Medical Benefits Act, and Medicare Parts A and B; another state's Title XIX, Title XXI or state-funded Medical Assistance Program; and personal estates.

Valid Claim: An invoice, in the form of a CMS 1500 claim form, submitted for payment of covered health services rendered to an eligible client that is submitted within the required 120 days from the date of service or discharge and that can be processed without obtaining additional information from the provider of the service or from a third party. A valid claim is synonymous with the federal definition of a clean claim as defined in 42 CFR 447.45(b).

EXHIBIT C
INSURANCE

During the term of this Contract, Contractor shall maintain in full force at its own expense, each insurance noted below:

1. **Workers Compensation.** Contractor, its subcontractors, if any, and all employers providing work, labor, or materials under this Contract are subject employers under the Oregon Workers' Compensation Law, and shall either comply with ORS 656.017, which requires said employers to provide workers' compensation coverage that satisfies Oregon law for all their subject workers, or shall comply with the exemption set out in ORS 656.126. Contractors shall maintain employer's liability insurance with limits of $500,000 each accident, $500,000 disease each employee, and $500,000 each policy limit.

2. **Professional Liability.** ☒ **Required by County** ☐ **Not required by County**

   Professional Liability insurance with a combined single limit, or the equivalent, of not less than $1,000,000 for each claim, incident, or occurrence, with an annual aggregate limit of $2,000,000. This is to cover damages because of personal injury, bodily injury, death, or damage to property caused by error, omission or negligent acts related to the professional services to be provided under this Contract. The policy must provide extending reporting period coverage for claims made within two years after the contract is completed.

   ☐ If this box is checked Professional Liability limits shall be $2,000,000 per occurrence and $4,000,000 in annual aggregate.

3. **General Liability.** ☒ **Required by County** ☐ **Not required by County**

   General Liability insurance with a combined single limit, or the equivalent, of not less than $1,000,000 for each claim, incident, or occurrence, with an annual aggregate limit of $2,000,000 for Bodily Injury and Property Damage for the protection of the **County and the State of Oregon, and its officers, elected officials, agents, and employees**. It shall include contractual liability coverage for the indemnity provided under this Contract.

   ☐ If this box is checked General Liability limits shall be $2,000,000 per occurrence and $4,000,000 in annual aggregate for bodily injury/death, and $200,000 per occurrence and $600,000 annual aggregate for property damage.

4. **Automobile Liability.** ☐ **Required by County** ☒ **Not required by County**

   ☐ **Commercial Automobile Liability** insurance with a combined single limit, or the equivalent, of not less than $1,000,000 for each accident for Bodily Injury, Death, and Property Damage, including coverage for owned, hired, or non-owned vehicles, as applicable.

   ☐ **Commercial Automobile Liability** insurance limits shall be $2,000,000 per occurrence and $4,000,000 in annual aggregate for bodily injury/death, and $200,000 per occurrence and $600,000 annual aggregate for property damage.

   ☐ **Personal Automobile Liability** insurance limits shall be not less than $250,000/occurrence, $500,000/aggregate, and $100,000/property damage.

5. **Physical Abuse and Molestation Liability.** ☐ **Required by County** ☒ **Not required by County**

Physical Abuse and Molestation Liability insurance with a combined single limit of not less than $1,000,000 each claim, incident, or occurrence, with an annual aggregate limit of $2,000,000. Coverage shall be provided through either general liability or professional liability coverage. Proof of Sex Abuse/Molestation insurance coverage must be provided.

6. **Privacy and Network Security.** ☒ **Required by County** ☐ **Not required by County**

Privacy and Network Security coverages shall be obtained and maintained to provide protection against liability for (a) system attack; (b) denial or loss of service attacks; (c) spread of malicious software code; (d) unauthorized access and use of computer systems; and (e) liability from the loss or disclosure of confidential data with limit of $1,000,000 per claim/annual aggregate.

☒ If this box is checked Privacy and Network Security limit shall be at least $4,000,000.

7. **Additional Insured Provision.** The insurance, other than Professional Liability (except to the extent it only applies to Commercial General Liability exposures), Workers' Compensation, Personal Automobile Liability and Pollution Liability Insurance, shall include **Clackamas County and the State of Oregon, and their officers, elected officials, agents, and employees** as an additional insured.

8. **Primary Coverage Clause.** Contractor's insurance shall apply as primary and will not seek contribution from any insurance or self-insurance maintained by, or provided to, the additional insureds listed above. This must be noted on the insurance certificate.

9. **Cross-Liability Clause.** A cross-liability clause or separation of insureds condition will be included in all general liability, professional liability, pollution and errors and omissions policies required by this Contract.

10. **"Tail" Coverage**. If any of the required insurance policies is on a "claims made" basis, such as professional liability insurance, the Contractor shall maintain either "tail" coverage or continuous "claims made" liability coverage, provided the effective date of the continuous "claims made" coverage is on or before the effective date of the Contract, for a minimum of twenty-four (24) months following the later of: (i) the Contractor's completion and County's acceptance of all Services required under the Provider Contract; or (ii) the expiration of all warranty periods provided under the Contract. Notwithstanding the foregoing 24-month requirement, if the Contractor elects to maintain "tail" coverage and if the maximum time period "tail" coverage reasonably available in the marketplace is less than the 24-month period described above, then the Contractor may request and County may grant approval of the maximum "tail" coverage period reasonably available in the marketplace. If County approval is granted, the Contractor shall maintain "tail" coverage for the maximum time period that "tail" coverage is reasonably available in the marketplace.

11. **Self-insurance**. Contractor may fulfill one or more of its insurance obligation herein through a program of self-insurance, provided that Contractor's self-insurance program complies with all applicable laws, provides coverage equivalent in both type and level to that required in this Exhibit, and is reasonably acceptable to County. Contractor shall furnish an acceptable insurance certificate to County for any insurance coverage required by this Contract that is fulfilled through self-insurance. Stop-loss insurance and reinsurance coverage against catastrophic and unexpected expenses may not be self-insured.

12. **Certificates of Insurance**. Contractor shall furnish evidence of the insurance required in this Contract. Contractor will maintain the insurance in full force throughout the duration of this Contract. No Contract shall be in effect until the required certificates have been received, approved, and accepted by County. A renewal certificate will be sent to County ten (10) days prior to coverage expiration. The insurance for general liability and commercial automobile liability must include an

endorsement naming **Clackamas County and the State of Oregon, and their officers, elected officials, agents, and employees** as additional insureds with respect to the Work under this Contract. If requested, complete copies of insurance policies, trust agreements, etc. shall be provided to the County. The Contractor shall be financially responsible for all pertinent deductibles, self-insured retentions and/or self-insurance.

Certificate Holder should be:

Clackamas County, 2051 Kaen Road, Suite 154, Oregon City, Oregon 97045

Certificates of Insurance should be submitted electronically or by mail to:

BHContracts@clackamas.us

Clackamas County
Contracts Administration
2051 Kaen Road, Suite 154
Oregon City, OR 97045

13. **Insurance Carrier Rating.** Coverages provided by the Contractor must be underwritten by an insurance company deemed acceptable by the County. Insurance coverage shall be provided by companies admitted to do business in Oregon or, in the alternative, rated A- or better by Best's Insurance Rating. The County reserves the right to reject all or any insurance carrier(s) with an unacceptable financial rating.

14. **Waiver of Subrogation.** Contractor agrees to waive their rights of subrogation arising from the Work performed under this Contract.

15. **Notice of cancellation or change**. There shall be no cancellation, material change, exhaustion of aggregate limits, reduction of limits, or intent not to renew the insurance coverage(s) without thirty (30) days written notice from the Contractor or its insurer(s) to the County at the following address: Clackamas County Behavioral Health Division, 2051 Kaen Road, Suite 154, Oregon City, OR 97045 or BHContracts@clackamas.us.

16. **Insurance Compliance.** The County will be entitled to enforce Contractor compliance with the insurance requirements, and will take all reasonable steps to enforce such compliance. Examples of "reasonable steps" include issuing stop work orders (or the equivalent) until the insurance is in full force, terminating the Contract as permitted by the Contract, or pursuing legal action to enforce the insurance requirements. In no event shall County permit a Contractor to work under this Contract when the County is aware that the Contractor is not in compliance with the insurance requirements.

EXHIBIT D
OHP REQUIRED FEDERAL TERMS AND CONDITIONS

Unless exempt under 45 CFR Part 87 for Faith-Based Organizations (Federal Register, July 16, 2004, Volume 69, #136), or other federal provisions, Contractor shall comply and, as indicated, cause all Subcontractors to comply with the following federal requirements to the extent that they are applicable. For purposes of this Contract, all references to federal and State laws are references to federal and State laws as they may be amended from time to time.

1. Miscellaneous Federal Provisions

Contractor shall comply and require all Subcontractors to comply with all federal laws, regulations and executive orders applicable to this Contract or to the delivery of Work. Without limiting the generality of the foregoing, Contractor expressly agrees to comply and require all Subcontractors to comply with the following laws, regulations and executive orders to the extent they are applicable to this Contract: (a)Title VI and VII of the Civil Rights Act of 1964, as amended, (b) 45 CFR Part 84 which implements, Title V, Sections 503 and 504 of the Rehabilitation Act of 1973, as amended, (c) the Americans with Disabilities Act of 1990, as amended, (d) Section 1557 of the Patient Protection and Affordable Care Act (ACA), (e) Executive Order 11246, as amended, (f) the Health Insurance Portability and Accountability Act of 1996, as amended, (g) the Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended, (h) the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, (i) the Mental Health Parity and Addiction Equity Act of 2008, as amended; (j) CMS regulations (including 42 CFR Part 438, subpart K) and guidance regarding mental health parity, including 42 CFR 438.900 et. seq.; (k) all regulations and administrative rules established pursuant to the foregoing laws, (l) all other applicable requirements of federal civil rights and rehabilitation statutes, rules and regulations, and (m) all federal laws requiring reporting of Member abuse. These laws, regulations and executive orders are incorporated by reference herein to the extent that they are applicable to this Contract and required by law to be so incorporated. No federal funds may be used to provide Work in violation of 42 U.S.C. 14402.

2. Equal Employment Opportunity

If this Contract, including amendments, is for more than $10,000, then Contractor shall comply and require all Subcontractors to comply with Executive Order 11246, entitled "Equal Employment Opportunity," as amended by Executive Order 11375, and as supplemented in Department of Labor regulations (41 CFR Part 60).

3. Clean Air, Clean Water, EPA Regulations

If this Contract, including amendments, exceeds $100,000 then Contractor shall comply and require all Subcontractors to comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 U.S.C. 7606), the Federal Water Pollution Control Act as amended (commonly known as the Clean Water Act) (33 U.S.C. 1251 to 1387), specifically including, but not limited to Section 508 (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations (2 CFR Part 1532), which prohibit the use under non-exempt federal contracts, grants or loans of facilities included on the EPA List of Violating Facilities. Violations shall be reported to OHA, United States Department of Health and Human Services and the appropriate Regional Office of the Environmental Protection Agency. Contractor shall include and require all Subcontractors to include in all contracts with Subcontractors receiving more than $100,000, language requiring the Subcontractor to comply with the federal laws identified in this section.

4. Energy Efficiency

Contractor shall comply and require all Subcontractors to comply with applicable mandatory standards and policies relating to energy efficiency that are contained in the Oregon energy conservation plan issued in compliance with the Energy Policy and Conservation Act, 42 U.S.C. 6201 et seq. (Pub. L. 94-163).

5. Truth in Lobbying

By signing this Contract, the Contractor certifies, to the best of the Contractor's knowledge and belief that:

a. No federal appropriated funds have been paid or will be paid, by or on behalf of Contractor, to any person for influencing or attempting to influence an officer or employee of an agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement.

b. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan or cooperative agreement, the Contractor shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying" in accordance with its instructions.

c. The Contractor shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients and Subcontractors shall certify and disclose accordingly.

d. This certification is a material representation of fact upon which reliance was placed when this Contract was made or entered into. Submission of this certification is a prerequisite for making or entering into this Contract imposed by Section 1352, Title 31, of the U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

e. No part of any federal funds paid to Contractor under this Contract shall be used other than for normal and recognized executive legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the United States Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government itself.

f. No part of any federal funds paid to Contractor under this Contract shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order proposed or pending before the United States Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative

relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

g. The prohibitions in subsections (e) and (f) of this section shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction an any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

h. No part of any federal funds paid to Contractor under this Contract may be used for any activity that promotes the legalization of any drug or other substance included in schedule I of the schedules of controlled substances established under Section 202 of the Controlled Substances Act except for normal and recognized executive congressional communications. This limitation shall not apply when there is significant medical evidence of a therapeutic advantage to the use of such drug or other substance of that federally sponsored clinical trials are being conducted to determine therapeutic advantage.

6. HIPAA Compliance

The parties acknowledge and agree that each of County and the Contractor is a "covered entity" for purposes of privacy and security provisions of the Health Insurance Portability and Accountability Act and its implementing federal regulations (collectively referred to as HIPAA). County and Contractor shall comply with HIPAA to the extent that any Work or obligations of County arising under this Contract are covered by HIPAA. Contractor shall develop and implement such policies and procedures for maintaining the privacy and security of records and authorizing the use and disclosure of records required to comply with this Contract and with HIPAA. Contractor shall comply and cause all Subcontractors to comply with HIPAA and the following:

a. Privacy and Security of Individually Identifiable Health Information. Individually Identifiable Health Information about specific individuals is protected from unauthorized use or disclosure consistent with the requirements of HIPAA. Individually Identifiable Health Information relating to specific individuals may be exchanged between Contractor and County for purposes directly related to the provision of services to clients which are funded in whole or in part under this Contract. However, Contractor shall not use or disclose any Individually Identifiable Health Information about specific individuals in a manner that would violate HIPAA Privacy Rules in 45 CFR Parts 160 and 164, OHA Privacy Rules, OAR Chapter 407 Division 014, or OHA Notice of Privacy Practices, if done by OHA. A copy of the most recent OHA Notice of Privacy Practices is posted on the OHA web site at: https://apps.state.or.us/cf1/FORMS/, Form number ME2090 Notice of Privacy Practices, or may be obtained from OHA.

b. HIPAA Information Security. Contractor shall adopt and employ reasonable administrative and physical safeguards consistent with the Security Rules in 45 CFR Part 164 to ensure that client information shall be used by or disclosed only to the extent necessary for the permitted use or disclosure and consistent with applicable State and federal laws and the terms and conditions of this Contract. Security incidents involving client information must be immediately reported to DHS' Privacy Officer.

c. Data Transactions Systems. Contractor shall comply with the HIPAA standards for electronic transactions published in 45 CFR Part 162 and the DHS EDT Rules, OAR 410-001-0000 through 410-001-0200. In order for Contractor to exchange electronic data transactions with OHA in connection with claims or encounter data, eligibility or Enrollment information, authorizations or other electronic transaction, Contractor shall execute an EDT Trading Partner Agreement with OHA and shall comply with the OHA EDT Rules.

d. Consultation and Testing. If Contractor reasonably believes that the Contractor's, County's or OHA's data transactions system or other application of HIPAA privacy or security compliance policy may result in a violation of HIPAA requirements, Contractor shall promptly consult the County or OHA HIPAA officer. Contractor, County, or OHA may initiate a request for testing of HIPAA transaction requirements, subject to available resources and OHA testing schedule.

7. Resource Conservation and Recovery

Contractor shall comply and require all Subcontractors to comply with all mandatory standards and policies that relate to resource conservation and recovery pursuant to the Resource Conservation and Recovery Act (codified at 42 U.S.C. 6901 et seq.). Section 6002 of that Act (codified at 42 U.S.C. 6962) requires that preference be given in procurement programs to the purchase of specific products containing recycled materials identified in guidelines developed by the Environmental Protection Agency. Current guidelines are set forth in 40 CFR Part 247.

8. Audits

a. Contractor shall comply, and require all subcontractors to comply, with applicable audit requirements and responsibilities set forth in this Contract and applicable state or federal law.

b. If Contractor expends $500,000 or more in Federal funds (from all sources) in its fiscal year beginning prior to December 26, 2014, Contractor shall have a single organization-wide audit conducted in accordance with the Single Audit Act. If Contractor expends $750,000 or more in federal funds (from all sources) in a fiscal year beginning on or after December 26, 2014, Contractor shall have a single organization-wide audit conducted in accordance with the provisions of 2 CFR Subtitle B with guidance at 2 CFR Part 200. Copies of all audits must be submitted to OHA within 30 days of completion. If Contractor expends less than $500,000 in Federal funds in a fiscal year beginning prior to December 26, 2014, or less than $750,000 in a fiscal year beginning on or after that date, Contractor is exempt from Federal audit requirements for that year. Records must be available as provided in Exhibit B, Part 8, Section 2.

9. Debarment and Suspension

Contractor shall, in accordance with 42 CFR 438.808(b), not permit any person or entity to be a Subcontractor if the person or entity is listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal Procurement or Nonprocurement Programs" in accordance with Executive Orders No. 12549 and No. 12689, "Debarment and Suspension". (See 2 CFR Part 180). This list contains the names of parties debarred, suspended, or otherwise excluded by agencies, and contractors declared ineligible under statutory authority other than Executive Order No.12549. Subcontractors with awards that exceed the simplified

acquisition threshold shall provide the required certification regarding their exclusion status and that of their principals prior to award.

Contractor shall ensure that no amounts are paid to a Provider that could be excluded from participation in Medicare or Medicaid for any of the following reasons:

a. The Provider is controlled by a sanctioned individual

b. The Provider has a contractual relationship that provides for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Social Security Act

c. The Provider employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:

(i) Any individual or entity excluded from participation in Federal health care programs.

(ii) Any entity that would provide those services through an excluded individual or entity.

The Contract prohibits the Contractor from knowingly having a person with ownership of 5% or more of the Contractor's equity if such person is (or is affiliated with a person or entity that is) debarred, suspended, or excluded from participation in federal healthcare programs.

If OHA learns that Contractor has a prohibited relationship with a person or entity that is debarred, suspended, or excluded from participation in federal healthcare programs, OHA:

a. Must notify DHHS of Contractor's noncompliance;

b. May continue an existing agreement with the Contractor unless DHHS directs otherwise; and

c. May not renew or extend the existing contract with the Contractor unless DHHS provides to the State a written statement describing compelling reasons that exist for renewing or extending the Contract, consistent with 42 CFR 438.610.

10. Pro-Children Act

Contractor shall comply and require all Subcontractors to comply with the Pro-Children Act of 1994 (codified at 20 U.S.C. Section 6081 et seq.).

11. Non-Discrimination

Contractor shall comply, and require its Subcontractors to comply, with all federal and State laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities) the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) of 1990, and all amendments to those acts and all regulations promulgated thereunder. Contractor shall also comply with all applicable requirements of State civil rights and rehabilitation statutes and rules.

12. OASIS

To the extent applicable, Contractor shall comply with, and shall require Subcontractors to comply with, the Outcome and Assessment Information Set (OASIS) reporting requirements and patient notice requirements for skilled services provided by Home Health Agencies, pursuant to CMS requirements published in 42 CFR 484.45, and such subsequent regulations as CMS may issue in relation to the OASIS program.

13. Patient Rights Condition of Participation

To the extent applicable, Contractor shall comply with, and shall require Subcontractors to comply with, the Patient Rights Condition of Participation (COP) that Hospitals must meet to continue participation in the Medicaid program, pursuant to 42 CFR Part 482. For purposes of this Contract, Hospitals include short-term, psychiatric, rehabilitation, long-term, and children's hospitals.

14. Federal Grant Requirements

The federal Medicaid rules establish that OHA and the County are recipients of federal financial assistance, and therefore are subject to federal grant requirements pursuant to 42 CFR 430.2(b). To the extent applicable to Contractor or to the extent OHA and/or the County requires Contractor to supply information or comply with procedures to permit OHA and/or the County to satisfy its obligations federal grant obligations or both, Contractor must comply with the following parts of 45 CFR:

a. Part 74, including Appendix A (uniform federal grant administration requirements);

b. Part 92 (uniform administrative requirements for grants to state, local and tribal governments);

c. Part 80 (nondiscrimination under Title VI of the Civil Rights Act);

d. Part 84 (nondiscrimination on the basis of handicap);

e. Part 91 (nondiscrimination on the basis of age);

f. Part 95 (Medicaid and CHIP federal grant administration requirements); and

g. Contractor shall not expend, and Contractor shall include a provision in any Subcontract that its Subcontractor shall not expend, any of the funds paid under this Contract for roads, bridges, stadiums, or any other item or service not covered under the OHP.

15. Mental Health Parity

Contractor shall adhere to CMS guidelines regarding Mental Health Parity detailed below:

a. If Contractor does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits provided to enrollees, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits;

b. If Contractor includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits provided to enrollees, it must either apply the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/surgical benefits and mental health or substance use disorder benefits; or not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is more restrictive than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits;

c. If Contractor includes an aggregate lifetime limit or annual dollar amount that applies to one-third or more but less than two-thirds of all medical/surgical benefits provided to enrollees, it must either impose no aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits; or impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits in accordance with 42 CFR 438.905(e)(ii);

d. Contractor must not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to enrollees (whether or not the benefits are furnished by Contractor).

e. If a member is provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or substance use disorder benefits must be provided to the member in every classification in which medical/surgical benefits are provided;

f. Contractor may not apply any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification;

g. Contractor may not apply more stringent utilization or Prior Authorization standards to mental health or substance use disorder, than standards that are applied to medical/surgical benefits.

h. Contractor may not impose Non-Quantitative Treatment Limitations (NQTL) for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification;

i. Contractor shall provide all necessary documentation and reporting required by OHA to establish and demonstrate compliance with 42 CFR part 438, subpart K regarding parity in mental health and substance use disorder benefits.

j. Contractor shall use processes, strategies, evidentiary standards or other factors in determining access to out of network providers for mental health or substance use disorder benefits that are comparable to and applied no more stringently than, the processes, strategies, evidentiary standards or other factors in determining access to out of network providers for medical/surgical benefits in the same classification.

EXHIBIT E
BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement is entered into upon signature ("Effective Date") by and between **Clackamas County, a political subdivision of the State of Oregon, on behalf of its Health, Housing and Human Services, Behavioral Health Division** ("Covered Entity") and **Lines for Life** ("Business Associate") in conformance with the Health Insurance Portability and Accountability Act of 1996, and its regulations ("HIPAA").

RECITALS

Whereas, the Covered Entity has engaged the services of the Business Associate, as defined under 45 CFR §160.103, for or on behalf of the Covered Entity;

Whereas, the Covered Entity may wish to disclose Individually Identifiable Health Information to the Business Associate in the performance of services for or on behalf of the Covered Entity as described in a Services Agreement ("Agreement");

Whereas, such information may be Protected Health Information ("PHI") as defined by the HIPAA Rules promulgated in accordance with the Administrative Simplification provisions of HIPAA;

Whereas, the Parties agree to establish safeguards for the protection of such information;

Whereas, the Covered Entity and Business Associate desire to enter into this Business Associate Agreement to address certain requirements under the HIPAA Rules;

Now, Therefore, the parties hereby agree as follows:

SECTION I – DEFINITIONS

1.1 "Breach" is defined as any unauthorized acquisition, access, use or disclosure of Unsecured PHI, unless the Covered Entity demonstrates that there is a low probability that the PHI has been compromised. The definition of Breach excludes the following uses and disclosures:

- 1.1.1 Unintentional access by a Covered Entity or Business Associate in good faith and within an Workforce member's course and scope of employment or placement;
- 1.1.2 Inadvertent one time disclosure between Covered Entity or Business Associate Work force members; and
- 1.1.3 The Covered Entity or Business Associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain the information.

1.2 "Covered Entity" shall have the meaning given to such term under the HIPAA Rules, including, but not limited to, 45 CFR §160.103.

1.3 "Designated Record Set" shall have the meaning given to such term under the HIPAA Rules, including, but not limited to 45 CFR §164.501.

1.4 "Effective Date" shall be the Effective Date of this Business Associate Agreement.

1.5 "Electronic Protected Health Information" or "Electronic PHI" shall have the meaning given to such term at 45 CFR §160.103, limited to information of the Covered Entity that the Business Associate creates, receives, accesses, maintains or transmits in electronic media on behalf of the Covered Entity under the terms and conditions of this Business Associate Agreement.

1.6 "Health Care Operations" shall have the meaning given to such term under the HIPAA Rules, including, but not limited to, 45 CFR §164.501.

1.7 "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules codified at 45 CFR Part 160 and Part 164.

1.8 "Individual" shall have the meaning given to such term in 45 CFR §160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR §164.502(g).

1.9 "Individually Identifiable Health Information" shall have the meaning given to such term under the HIPAA Rules, including, but not limited to 45 CFR §160.103.

1.10 "Protected Health Information" or "PHI" means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an Individual; the provision of health care to an Individual; or the past, present or future payment for the provision of health care to an Individual; and (ii) that identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual, and shall have the meaning given to such term under the HIPAA Rules, 45 CFR §160.103 and §164.501.

1.11 "Protected Information" shall mean PHI provided by the Covered Entity to Business Associate or created, maintained, transmitted or received by Business Associate on Covered Entity's behalf.

1.12 "Required by Law" shall have the meaning given to such phrase in 45 CFR §164.103.

1.13 "Secretary" shall mean the Secretary of the Department of Health and Human Services or his or her designee.

1.14 "Security Incident" shall have the meaning given to such phrase in 45 CFR §164.304.

1.15 "Unsecured Protected Health Information" shall mean protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in accordance with 45 CFR §164.402.

1.16 Workforce means employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a Covered Entity or Business Associate, is under the direct control of such Covered Entity or Business Associate, whether or not they are paid by the Covered Entity or Business Associate.

SECTION II – OBLIGATIONS AND ACTIVITIES OF THE BUSINESS ASSOCIATE

The Business Associate agrees to the following:

2.1 Not to use or further disclose PHI other than as permitted or required by this Business Associate Agreement or as Required by Law;

2.2 To use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to Electronic PHI, to prevent use or disclosure of PHI other than as provided for by this Business Associate Agreement;

2.3 To mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of a use or disclosure of PHI by the Business Associate in violation of the requirements of this Business Associate Agreement;

2.4 To immediately report to the Covered Entity any use or disclosure of PHI not provided for by this Business Associate Agreement of which it becomes aware, including any Security Incident of which it becomes aware;

2.5 In accordance with 45 CFR §§164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any agent, including a subcontractor, that creates, receives, maintains, or transmits PHI on behalf of the Business Associate agrees in writing to the same restrictions, conditions and requirements that apply to the Business Associate with respect to such PHI;

2.6 To provide access, at the request of the Covered Entity, and in the time and manner designated by the Covered Entity, to PHI in a Designated Record Set, to the Covered Entity or, as directed by the Covered Entity, to the Individual or the Individual's designee as necessary to meet the Covered Entity's obligations under 45 CFR §164.524; provided, however, that this Section 2.6 is applicable

only to the extent the Designated Record Set is maintained by the Business Associate for the Covered Entity;

2.7 To make any amendment(s) to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR §164.526 at the request of the Covered Entity or an Individual, and in the time and manner designated by the Covered Entity; provided, however, that this Section 2.7 is applicable only to the extent the Designated Record Set is maintained by the Business Associate for the Covered Entity;

2.8 To make internal practices, books and records, including policies and procedures on PHI, relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of, the Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary's determining the Covered Entity's and the Business Associate's compliance with the HIPAA Rules;

2.9 To document such disclosures of PHI and information related to such disclosures as would be required for the Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528;

2.10 To provide to the Covered Entity or an Individual, in a time and manner designated by the Covered Entity, information collected in accordance with Section 2.9 of this Business Associate Agreement, to permit the Covered Entity to respond to a request by an accounting of disclosures of PHI in accordance with 45 CFR §164.528;

2.11 That if it creates, receives, maintains, or transmits any Electronic PHI on behalf of the Covered Entity, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. The Business Associate will report to the Covered Entity any Security Incident of which it becomes aware;

2.12 To retain records related to the PHI hereunder for a period of six (6) years unless the Business Associate Agreement is terminated prior thereto. In the event of termination of this Business Associate Agreement, the provisions of Section V of this Business Associate Agreement shall govern record retention, return or destruction;

2.13 To promptly notify the Covered Entity of a Breach of Unsecured PHI as soon as practicable, but in no case later than 10 calendar days, after the discovery of such Breach in accordance with 45 CFR §164.410. A Breach shall be treated as discovered as of the first day on which such Breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the Breach, who is an employee, officer, or agent of Business Associate. The notification shall include, to the extent possible, the identification of each Individual whose Unsecured PHI has been, or is reasonably believed by Business Associate to have been, accessed, acquired, used, or disclosed during the Breach in addition to the information required in Section V. In addition, Business Associate shall provide the Covered Entity with any other available information that the Covered Entity is required to include in the notification to the individual under 45 CFR §164.404(c); and

2.14 To the extent Business Associate is to carry out one or more of the Covered Entity's obligations under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the Covered Entity in the performance of such obligations.

SECTION III – THE PARTIES AGREE TO THE FOLLOWING PERMITTED USES AND DISCLOSURES BY THE BUSINESS ASSOCIATE:

3.1 Business Associate agrees to make uses and disclosures and requests for PHI consistent with the Covered Entity's minimum necessary policies and procedures.

3.2 Except as otherwise limited in this Business Associate Agreement, the Business Associate may use or disclose PHI to perform functions, activities or services for, or on behalf of, the Covered Entity as specified in the Services Agreement, provided that such use or disclosure would not violate the HIPAA Rules if done by the Covered Entity; and,

3.3 Except as otherwise limited in this Business Associate Agreement, the Business Associate may:

a. **Use for management and administration**. Use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate; and,

b. **Disclose for management and administration**. Disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that disclosures are Required by Law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as Required by Law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

SECTION IV – NOTICE OF PRIVACY PRACTICES

4.1 If requested, the Covered Entity shall provide the Business Associate with the notice of privacy practices that the Covered Entity produces in accordance with 45 CFR §164.520, as well as any changes to such notice. Covered Entity shall (a) provide the Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect the Business Associate's permitted or required uses and disclosures; (b) notify the Business Associate of any restriction to the use or disclosure of PHI that the Covered Entity has agreed to in accordance with 45 CFR §164.522, to the extent that such restrictions may affect the Business Associate's use or disclosure of PHI; and (c) not request the Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Standards if done by the Covered Entity, except as set forth in Section 3.2 above.

SECTION V – BREACH NOTIFICATION REQUIREMENTS

5.1 With respect to any Breach, the Covered Entity shall notify each individual whose Unsecured PHI has been, or is reasonably believed by the Covered Entity to have been, accessed, acquired, used, or disclosed as a result of such Breach, except when law enforcement requires a delay pursuant to 45 CFR §164.412. This notice shall be:

a. Without unreasonable delay and in no case later than 60 calendar days after discovery of a Breach.

b. In plain language including and to the extent possible:

1) A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;

2) A description of the types of Unsecured PHI that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

3) Any steps Individuals should take to protect themselves from potential harm resulting from the Breach;

4) A brief description of what the Covered Entity and/or Business Associate is doing to investigate the Breach, to mitigate harm to Individuals, and to protect against any further Breaches; and,

5) Contact procedures for Individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, web site, or postal address.

c. By a method of notification that meets the requirements of 45 CFR §164.404(d).

d. Provided to the media when required under 45 CFR §164.406 and to the Secretary pursuant to 45 CFR §164.408.

5.2. Business Associate shall promptly provide any information requested by Covered Entity to provide the information described in Section 5.1.

SECTION VI – TERM AND TERMINATION

6.1 **Term**. The term of this Business Associate Agreement shall be effective as of the date set forth above in the first paragraph and shall terminate when all of the PHI created, maintained, transmitted or received by the Business Associate on behalf of the Covered Entity, is destroyed or returned to the Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.

6.2 **Termination for Cause**. Upon the Covered Entity's knowledge of a material breach of this Business Associate Agreement by the Business Associate, the Covered Entity shall provide an opportunity for the Business Associate to cure the breach or end the violation. The Covered Entity shall terminate this Business Associate Agreement and the Services Agreement if the Business Associate does not cure the breach or end the violation within the time specified by the Covered Entity, or immediately terminate this Business Associate Agreement if cure is not reasonably possible.

If the Business Associate fails to cure a breach for which cure is reasonably possible, the Covered Entity may take action to cure the breach, including but not limited to obtaining an injunction that will prevent further improper use or disclosure of PHI. Should such action be taken, the Business Associate agrees to indemnify the Covered Entity for any costs, including court costs and attorneys' fees, associated with curing the breach.

Upon the Business Associate's knowledge of a material breach of this Business Associate Agreement by the Covered Entity, the Business Associate shall provide an opportunity for the Covered Entity to cure the breach or end the violation. The Business Associate shall terminate this Business Associate Agreement and the Services Agreement if the Covered Entity does not cure the breach or end the violation within the time specified by the Business Associate, or immediately terminate this Business Associate Agreement if the Covered Entity has breached a material term of this Business Associate Agreement if cure is not reasonably possible.

6.3 **Effect of Termination**.

a. **Return or Destruction of PHI**. Except as provided in Section 6.3(b), upon termination of this Business Associate Agreement, for any reason, the Business Associate shall return, or if agreed to by the Covered Entity, destroy all PHI received from the Covered Entity, or created, maintained or received by the Business Associate on behalf of the Covered Entity and retain no copies. This provision shall apply to PHI that is in the possession of subcontractors or agents of the Business Associate.

b. **Return or Destruction of PHI Infeasible**. In the event that the Business Associate determines that returning or destroying PHI is infeasible, the Business Associate shall provide to the Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the parties that return or destruction of the PHI is infeasible, the Business

Associate shall extend the protections of this Business Associate Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as the Business Associate maintains such PHI. In addition, the Business Associate shall continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to Electronic PHI to prevent use or disclosure of the PHI, for as long as the Business Associate retains the PHI.

SECTION VII – GENERAL PROVISIONS

7.1 **Regulatory references**. A reference in this Business Associate Agreement to the HIPAA Rules or a section in the HIPAA Rules means that Rule or Section as in effect or as amended from time to time.

7.2 **Compliance with law**. In connection with its performance under this Business Associate Agreement, Business Associate shall comply with all applicable laws, including but not limited to laws protecting the privacy of personal information about Individuals.

7.3 **Amendment**. The Parties agree to take such action as is necessary to amend this Business Associate Agreement from time to time. All amendments must be in writing and signed by both Parties.

7.4 **Indemnification by Business Associate**. Business Associate agrees to indemnify, defend and hold harmless the Covered Entity and its commissioners, employees, directors, officers, subcontractors, agents or other members of its workforce, each of the foregoing hereinafter referred to as "Indemnified Party," against all actual and direct losses suffered by the Indemnified Party and all liability to third parties arising from or in connection with Business Associate's breach of Sections II and III of this Business Associate Agreement. Accordingly, on demand, Business Associate shall reimburse any Indemnified Party for any and all actual and direct losses, liabilities, fines, penalties, costs or expenses (including reasonable attorneys' fees) which may for any reason be imposed upon any Indemnified Party by reason of any suit, claim, action, proceeding or demand by any third party which results for Business Associate's breach hereunder. The obligation to indemnify any Indemnified Party shall survive the expiration or termination of this Agreement for any reason.

7.5 **Survival**. The respective rights and obligations of Business Associate under Section II of this Business Associate Agreement shall survive the termination of the Services Agreement and this Business Associate Agreement.

7.6 **Interpretation**. Any ambiguity in this Business Associate Agreement shall be resolved to permit Covered Entity to comply with the HIPAA Rules.

[*Signature Page for BAA Follows*]

SIGNATURE PAGE FOR BUSINESS ASSOCIATE AGREEMENT

The Parties hereto have duly executed this Agreement as of the Effective Date as defined here above.

Business Associate	**Covered Entity**
Lines For Life	**CLACKAMAS COUNTY**
David Westbrook Digitally signed by David Westbrook Date: 2021.11.15 13:05:55 -08'00'	
Authorized Signature Date	Chair Date
Name / Title (Printed)	

Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

December 2, 2021

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of a Local Subrecipient Grant Agreement for Todos Juntos
to provide Family Resource Coordinators in Clackamas County Agreement is $149,119
funded through
Oregon Early Learning Division and Clackamas County General Fund

Purpose/Outcome	Todos Juntos will continue to provide Family Resource Coordinators (FRC's) to connect families with children ages 0-6, who experience barriers to school success, with holistic services that promote family stability, healthy child development, and school readiness. The FRC's will operate in the specified Health Equity Zone of Rural Clackamas County to receive, coordinate, and expedite service referrals for families to help them navigate healthcare, education, and other human service systems that facilitate family stability and access to necessary services.
Dollar Amount and Fiscal Impact	Agreement has a maximum value of $149,119 and terminates on December 31, 2022 Clackamas County General Funds are involved
Funding Source	State of Oregon, Dept of Education through its Early Learning Division ($49,119) and Clackamas County General Fund through its Children, Family & Community Connections Division ($100,000).
Duration	This amendment is effective October 1, 2021 for services ending December 31, 2022
Previous Board Action/Review	Board Issues Date: 11/30/21
Strategic Plan Alignment	1. Ensure safe, healthy and secure communities
Counsel Review	This Subrecipient Grant agreement has been reviewed and approved by County Counsel on 11/10/21 , KR
Procurement Review	Was the item processed through Procurement? No. Subrecipient selected through a competitive process
Contact Person	Adam Freer 971-533-4929
Contract No.	CFCC #10425

BACKGROUND:
The Children, Family & Community Connections Division of the Health, Housing and Human Services Department requests approval of a Local Subrecipient Grant Agreement with Todos Juntos to continue to provide Family Resource Coordinators in the Health Equity Zones of Rural Clackamas County. Todos Juntos was selected through a competitive process in 2019 to provide Family Resource Coordination in Clackamas County. The FRC coordinates referrals for families, prioritizing those whose children ages 0-6

experience barriers to school success, and follows-up with families and service providers to ensure timely access and assure that services have effectively met mutually identified needs.

This Local Subrecipient Grant Agreement is effective upon signature by all parties for services starting on October 1, 2021 and terminating on December 31, 2022. This Agreement has a maximum value of $149,119.

RECOMMENDATION:
Staff recommends the Board approval of this Agreement and authorization for Tootie Smith, Board Chair, to sign on behalf of Clackamas County.

Respectfully submitted,

Rodney Cook

Rodney A. Cook, Director
Health, Housing & Human Services

CLACKAMAS COUNTY, OREGON

LOCAL SUBRECIPIENT GRANT AGREEMENT CFCC- 10425

Program Name: ***Family Resource Coordination***

Program/Project Number: 10425

This Agreement is between **Clackamas County, Oregon**, acting by and through its Health, Housing & Human Services Children, Family & Community Connections Division (COUNTY) and **Todos Juntos** (SUBRECIPIENT), an Oregon Non-profit Organization.

COUNTY Data	
Grant Accountant: Joseph Rosevear	Program Manager: ***Dani Stamm Thomas***
Clackamas County Finance 2051 Kaen Road Oregon City, OR 97045 (503) 742-5429 jrosevear@clackamas.us	Children, Family & Community Connections 112 11th Street Oregon City, OR 97045 (971) 288-8264 dstammthomas@clackamas.us
SUBRECIPIENT Data	
Finance/Fiscal Representative: Eric Johnston	Program Representative: Shawna Johnson
Todos Juntos PO Box 645 Canby, OR 97013	Todos Juntos PO Box 645 Canby, OR 97013 shawnaj@todos-juntos.net
FEIN: 93-1308023	

RECITALS

1. Todos Juntos (SUBRECIPIENT), a local Nonprofit 501(c)(3) organization, was selected through a competitive process in 2019 to provide Family Resource Coordinators in Rural Clackamas County. The Family Resource Coordinator operates in a specified Health Equity Zone to receive, coordinate, and expedite service referrals for families with children ages 0-6 to assist families in navigating healthcare, education, and other human services systems that facilitate family stability and access to necessary services

2. SUBRECIPIENT will refer and connect families with children ages 0-6, who experience barriers to school success, to holistic services that promote family stability, healthy child development, and school readiness.

3. This Agreement of financial assistance sets forth the terms and conditions pursuant to which SUBRECIPIENT agrees on delivery of the Program.

NOW THEREFORE, according to the terms of this Local SUBRECIPIENT Agreement, COUNTY and SUBRECIPIENT agree as follows:

AGREEMENT

1. **Term and Effective Date.** This Agreement shall become effective on the date it is fully executed and approved as required by applicable law. Funds issued under this Agreement may be used to reimburse SUBRECIPIENT for expenses approved in writing by County relating to the project incurred no earlier than **October 1, 2021** and not later than **December 31, 2022**, unless this Agreement is sooner terminated or extended pursuant to the terms hereof. No grant funds are available for expenditures after the expiration date of this Agreement.

2. **Program.** The Program is described in Attached Exhibit A: SUBRECIPIENT Scope of Work. SUBRECIPIENT agrees to perform the Program in accordance with the terms and conditions of this Agreement.

3. **Standards of Performance.** SUBRECIPIENT shall perform all activities and programs in accordance with the requirements set forth in this Agreement and all applicable laws and regulations. Furthermore, SUBRECIPIENT shall comply with the requirements of Clackamas County and the Oregon Early Learning Division HUB Grant Agreement.

4. **Grant Funds**. COUNTY's funding for this Agreement is Clackamas County General Funds (**$100,000**) and Oregon Early Learning Division HUB Coordination Grant issued to COUNTY (**$46,119)**. The maximum, not to exceed, grant amount that COUNTY will pay on this Agreement is **$146,119.**

5. **Disbursements**. This is a cost reimbursement grant and disbursements will be made in accordance with the requirements contained in Exhibit D: Request for Reimbursement.

   Failure to comply with the terms of this Agreement may result in withholding of payment.

6. **Amendments.** The terms of this Agreement shall not be waived, altered, modified, supplemented, or amended, in any manner whatsoever, except by written instrument signed by both parties. **SUBRECIPIENT must submit a written request including a justification for any amendment to the COUNTY in writing at least forty five (45) calendar days before this Agreement expires.** No payment will be made for any services performed before the beginning date or after the expiration date of this Agreement. If the maximum compensation amount is increased by amendment, the amendment must be fully effective before SUBRECIPIENT performs work subject to the amendment.

7. **Termination.** This Agreement may be suspended or terminated prior to the expiration of its term by:
   a. Written notice provided by COUNTY resulting from material failure by SUBRECIPIENT to comply with any term of this Agreement, or;
   b. Mutual agreement by COUNTY and SUBRECIPIENT.
   c. Written notice provided by COUNTY that funds are no longer available for this purpose.

      Upon completion of improvements or upon termination of this Agreement, any unexpended balances of funds shall remain with COUNTY.

   Effect of Termination. The expiration or termination of this Agreement, for any reason, shall not release SUBRECIPIENT from any obligation or liability to COUNTY, or any requirement or obligation that:
   d. Has already accrued hereunder;
   e. Comes into effect due to the expiration or termination of the Agreement; or
   f. Otherwise survives the expiration or termination of this Agreement.

   Following the termination of this Agreement, SUBRECIPIENT shall promptly identify all unexpended funds and return all unexpended funds to COUNTY. Unexpended funds are those funds received by SUBRECIPIENT under this Agreement that (i) have not been spent or expended in accordance

with the terms of this Agreement; and (ii) are not required to pay allowable costs or expenses that will become due and payable as a result of the termination of this Agreement

8. **Funds Available and Authorized.** COUNTY certifies that it has been awarded funds sufficient to finance the costs of this Agreement. SUBRECIPIENT understands and agrees that payment of amounts under this Agreement is contingent on COUNTY receiving appropriations or other expenditure authority sufficient to allow COUNTY, in the exercise of its reasonable administrative discretion, to continue to make payments under this Agreement.

9. **Future Support.** COUNTY makes no commitment of future support and assumes no obligation for future support for the activity contracted herein except as set forth in this agreement.

10. **Nonprofit status.** SUBRECIPIENT warrants that it is, and shall remain during the performance of this Agreement, a private nonprofit Organization as defined in the Regulations, including:
    a. That it is described in Section 501(c) of the Internal Revenue Code of 1954;
    b. That it is exempt from taxation under Subtitle A of the Internal Revenue Code of 1954;
    c. That it has an accounting system and a voluntary board; and
    d. That it practices nondiscrimination in the provision of its services.

11. **Administrative Requirements**. SUBRECIPIENT agrees to its status as a SUBRECIPIENT, and accepts among its duties and responsibilities the following:

    a) **Financial Management.** SUBRECIPIENT shall comply with Generally Accepted Accounting Principles (GAAP) or another equally accepted basis of accounting, use adequate internal controls, and maintain necessary sources documentation for all costs incurred.

    b) **Revenue Accounting.** Grant revenue and expenses generated under this Agreement should be recorded in compliance with generally accepted accounting principles and/or governmental accounting standards. This requires that the revenues are treated as unearned income or “deferred” until the compliance requirements and objectives of the grant have been met. Revenue may be recognized throughout the life cycle of the grant as the funds are “earned”. All grant revenues not fully earned and expended in compliance with the requirements and objectives at the end of the period of performance must be returned to the County within 15 days.

    c) **Budget.** SUBRECIPIENT use of funds may not exceed the amounts specified in the Exhibit B: SUBRECIPIENT Program Budget. SUBRECIPIENT agrees to expend funds in accordance with the approved budget provided in this agreement. All expenditures that exceed a budget line item by more than 10% or $500, whichever is greater, must be approved in writing by COUNTY. Budget revisions must be submitted and approved prior to changing the budget. At no time may budget modifications change the scope of the original grant application or agreement.

    d) **Allowable Uses of Funds**. SUBRECIPIENT shall use funds only for those purposes authorized in this Agreement and in accordance with Clackamas County and Oregon Early Learning Division.

    e) **Period of Availability.** SUBRECIPIENT may charge to the award only allowable costs resulting from obligations incurred during the term and effective date. Cost incurred prior or after this date will be disallowed.

    f) Match. Matching funds are not required for this Agreement**.**

g) **Payment.** Routine requests for reimbursement should be submitted monthly by the 15th of the following month using the form and instructions in Exhibit D: Request for Reimbursement. SUBRECIPIENT must submit a final request for payment no later than fifteen (15) days after the end date of this Agreement.

h) **Performance and Financial Reporting.** SUBRECIPIENT must submit Performance Reports according to the schedule specified in Exhibit C: SUBRECIPIENT Performance Reporting. SUBRECIPIENT must submit Financial Reports according to the schedule specified in Exhibit D: Request for Reimbursement. All reports must be signed and dated by an authorized official of SUBRECIPIENT.

i) **Audit**. SUBRECIPIENT shall comply with the audit requirements prescribed by State and Federal law.

j) **Monitoring.** SUBRECIPIENT agrees to allow access to conduct site visits and inspections of financial and programmatic records for the purpose of monitoring. COUNTY, and its duly authorized representatives shall have access to such records and other books, documents, papers, plans, records of shipments and payments and writings of SUBRECIPIENT that are pertinent to this Agreement, whether in paper, electronic or other form, to perform examinations and audits and make excerpts, copies and transcripts. Monitoring may be performed onsite or offsite, at COUNTY's discretion.

k) **Record Retention**. SUBRECIPIENT will retain and keep accessible all such financial records, books, documents, papers, plans, records of shipments and payments and writings for a minimum of six (6) years following the Project End Date (June 30, 2021), or such longer period as may be required by applicable law, or until the conclusion of any audit, controversy or litigation arising out of or related to this Agreement, whichever date is later.

l) **Failure to Comply.** SUBRECIPIENT acknowledges and agrees that this agreement and the terms and conditions therein are essential terms in allowing the relationship between COUNTY and SUBRECIPIENT to continue, and that failure to comply with such terms and conditions represents a material breach of the original contract and this agreement. Such material breach shall give rise to COUNTY's right, but not obligation, to withhold SUBRECIPIENT grant funds until compliance is met, reclaim grant funds in the case of omissions or misrepresentations in financial or programmatic reporting, or to terminate this relationship including the original contract and all associated amendments.

12. **Compliance with Applicable Laws**

a) **Public Policy**. SUBRECIPIENT expressly agrees to comply with all public policy requirements, laws, regulations, and executive orders issued by the Federal government, to the extent they are applicable to the Agreement: (i) Titles VI and VII of the Civil Rights Act of 1964, as amended; (ii) Sections 503 and 504 of the Rehabilitation Act of 1973, as amended; (iii) the Americans with Disabilities Act of 1990, as amended; (iv) Executive Order 11246, as amended; (v) the Health Insurance Portability and Accountability Act of 1996; (vi) the Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended; (vii) the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended; (viii) all regulations and administrative rules established pursuant to the foregoing laws; and (ix) all other applicable requirements of federal and state civil rights and rehabilitation statutes, rules and regulations; and as applicable to SUBRECIPIENT.

b) **State Statutes**. SUBRECIPIENT expressly agrees to comply with all statutory requirements, laws, rules, and regulations issued by the State of Oregon, to the extent they are applicable to the agreement.

c) **Conflict Resolution.** If conflicts are discovered among federal, state and local statutes, regulations, administrative rules, executive orders, ordinances and other laws applicable to the Services under the Agreement, SUBRECIPIENT shall in writing request COUNTY resolve the conflict. SUBRECIPIENT shall specify if the conflict(s) create a problem for the design or other Services required under the Agreement.

General Agreement Provision

a) **Non-appropriation Clause.** If payment for activities and programs under this Agreement extends into COUNTY's next fiscal year, COUNTY's obligation to pay for such work is subject to approval of future appropriations to fund the Agreement by the Board of County Commissioners.

b) **Indemnification.** SUBRECIPIENT agrees to indemnity and hold COUNTY harmless with respect to any claim, cause, damage, action, penalty or other cost (including attorney's and expert fees) arising from or related to SUBRECIPIENT's negligent or willful acts or those of its employees, agents or those under SUBRECIPIENT's control. SUBRECIPIENT is responsible for the actions of its own agents and employees, and COUNTY assumes no liability or responsibility with respect to SUBRECIPIENT's actions, employees, agents or otherwise with respect to those under its control.

c) **Insurance**. During the term of this agreement, SUBRECIPIENT shall maintain in force, at its own expense, each insurance noted below:

1) **Commercial General Liability**. SUBRECIPIENT shall obtain, at SUBRECIPIENT's expense, and keep in effect during the term of this agreement, Commercial General Liability Insurance covering bodily injury, death, and property damage on an "occurrence" form in the amount of not less than $1,000,000 per occurrence/ $2,000,000 general aggregate for the protection of COUNTY, its officers, commissioners, and employees. This coverage shall include Contractual Liability insurance for the indemnity provided under this agreement. This policy(s) shall be primary insurance as respects to COUNTY. Any insurance or self-insurance maintained by COUNTY shall be excess and shall not contribute to it.

2) **Commercial Automobile Liability**. If the Agreement involves the use of vehicles, SUBRECIPIENT shall obtain at SUBRECIPIENT expense, and keep in effect during the term of this agreement, Commercial Automobile Liability coverage including coverage for all owned, hired, and non-owned vehicles. The combined single limit per occurrence shall not be less than $1,000,000.

3) **Professional Liability**. If the Agreement involves the provision of professional services, SUBRECIPIENT shall obtain and furnish COUNTY evidence of Professional Liability Insurance covering any damages caused by an error, omission, or negligent act related to the services to be provided under this agreement, with limits not less than $2,000,000 per occurrence for the protection of COUNTY, its officers, commissioners and employees against liability for damages because of personal injury, bodily injury, death, or damage to property, including loss of use thereof, and damages because of negligent acts, errors and omissions in any way related to this agreement. COUNTY, at its option, may require a complete copy of the above policy.

4) **Workers' Compensation.** Insurance in compliance with ORS 656.017, which requires all employers that employ subject workers, as defined in ORS 656.027, to provide workers' compensation coverage for those workers, unless they meet the requirement for an exemption under ORS 656.126(2). If contractor is a subject employer, as defined in ORS 656.023, contractor shall obtain employers' liability insurance coverage limits of not less than $1,000,000.

5) **Additional Insured Provisions**. All required insurance, other than Professional Liability, Workers' Compensation, and Personal Automobile Liability and Pollution Liability Insurance, shall include "Clackamas County, its agents, officers, and employees" as an additional insured, as well as the but only with respect to SUBRECIPIENT's activities under this agreement.

6) **Minors.** Contractor shall carry Abuse and Molestation Insurance as an endorsement to the Commercial General Liability policy, in a form and with coverage that are satisfactory to the County, covering damages arising out of actual or threatened physical abuse, mental injury, sexual molestation, negligent: hiring, employment, supervision, investigation, reporting to proper authorities, and retention of any person for whom the Contractor is responsible including but not limited to Contractor and Contractor's employees and volunteers. Policy endorsement's definition of an insured shall include the Contractor, and the Contractor's employees and volunteers. Coverage shall be written on an occurrence basis in an amount of not less than $1,000,000 per occurrence. Any annual aggregate limit shall not be less than $3,000,000. These limits shall be exclusive to this required coverage. Incidents related to or arising out of physical abuse, mental injury, or sexual molestation, whether committed by one or more individuals, and irrespective of the number of incidents or injuries or the time period or area over which the incidents or injuries occur, shall be treated as a separate occurrence for each victim. Coverage shall include the cost of defense and the cost of defense shall be provided outside the coverage limit.

7) **Notice of Cancellation.** There shall be no cancellation, material change, exhaustion of aggregate limits or intent not to renew insurance coverage without 30 days written notice to the COUNTY. Any failure to comply with this provision will not affect the insurance coverage provided to COUNTY. The 30 day notice of cancellation provision shall be physically endorsed on to the policy.

8) **Insurance Carrier Rating**. Coverage provided by SUBRECIPIENT must be underwritten by an insurance company deemed acceptable by COUNTY. Insurance coverage shall be provided by companies admitted to do business in Oregon or, in the alternative, rated A- or better by Best's Insurance Rating. COUNTY reserves the right to reject all or any insurance carrier(s) with an unacceptable financial rating.

9) **Certificates of Insurance.** As evidence of the insurance coverage required by this agreement, SUBRECIPIENT shall furnish a Certificate of Insurance to COUNTY. No agreement shall be in effect until the required certificates have been received, approved, and accepted by COUNTY. A renewal certificate will be sent to COUNTY 10 days prior to coverage expiration.

10) **Primary Coverage Clarification**. SUBRECIPIENT coverage will be primary in the event of a loss and will not seek contribution from any insurance or self-insurance maintained by, or provided to, the additional insureds listed above.

11) **Cross-Liability Clause**. A cross-liability clause or separation of insured's condition will be included in all general liability, professional liability, and errors and omissions policies required by the agreement.

Waiver of Subrogation. SUBRECIPIENT agrees to waive their rights of subrogation arising from the work performed under this Agreement.

a) **Assignment.** SUBRECIPIENT shall not enter into any subcontracts or subawards for any of the Program activities required by the Agreement without prior written approval. This Agreement may not be assigned in whole or in part with the express written approval of COUNTY.

b) **Independent Status.** SUBRECIPIENT is independent of COUNTY and will be responsible for any federal, state, or local taxes and fees applicable to payments hereunder. SUBRECIPIENT is not an agent of COUNTY and undertakes this work independent from the control and direction of COUNTY excepting as set forth herein. SUBRECIPIENT shall not seek or have the power to bind COUNTY in any transaction or activity.

c) **Notices.** Any notice provided for under this Agreement shall be effective if in writing and (1) delivered personally to the addressee or deposited in the United States mail, postage paid, certified mail, return receipt requested, (2) sent by overnight or commercial air courier (such as Federal Express), (3) sent by facsimile transmission, with the original to follow by regular mail; or, (4) sent by electronic mail with confirming record of delivery confirmation through electronic mail return-receipt, or by confirmation that the electronic mail was accessed, downloaded, or printed. Notice will be deemed to have been adequately given three days following the date of mailing, or immediately if personally served. For service by facsimile or by electronic mail, service will be deemed effective at the beginning of the next working day.

d) **Governing Law.** This Agreement is made in the State of Oregon, and shall be governed by and construed in accordance with the laws of that state. Any litigation between COUNTY and SUBRECIPIENT arising under this Agreement or out of work performed under this Agreement shall occur, if in the state courts, in the Clackamas County court having jurisdiction thereof, and if in the federal courts, in the United States District Court for the State of Oregon.

e) **Severability**. If any provision of this Agreement is found to be illegal or unenforceable, this Agreement nevertheless shall remain in full force and effect and the provision shall be stricken.

f) **Counterparts.** This Agreement may be executed in any number of counterparts, all of which together will constitute one and the same agreement. Facsimile copy or electronic signatures shall be valid as original signatures.

g) **Third Party Beneficiaries**. Except as expressly provided in this Agreement, there are no third party beneficiaries to this Agreement. The terms and conditions of this Agreement may only be enforced by the parties.

h) **Binding Effect.** This Agreement shall be binding on all parties hereto, their heirs, administrators, executors, successors and assigns.

i) **Integration**. This agreement contains the entire agreement between COUNTY and SUBRECIPIENT and supersedes all prior written or oral discussions or agreements.

SUBRECIPIENT
Todos Juntos
PO Box 645
Canby, OR 97013

CLACKAMAS COUNTY
Commissioner Tootie Smith, Chair
Commissioner Sonya Fischer
Commissioner Paul Savas
Commissioner Martha Schrader
Commissioner Mark Shull

By: Eric Johnston
Eric Johnston, Executive Director

Dated: 11-10-2021

By: _____
Tootie Smith, Board Chair
Clackamas County

Dated: _____

- Exhibit A-1: Scope of Work
- Exhibit A-2: Work Plan Quarterly Report
- Exhibit B: Program Budget
- Exhibit C: Quarterly Demographic Report
- Exhibit D-1: Request for Reimbursement
- Exhibit D-2: Monthly Activity Report

EXHIBIT A-1
SCOPE OF WORK

Contractor shall provide Family Resource Coordination Services ("Work") as described in this Exhibit A-1 and A-2.

The Early Learning Hub of Clackamas County receives its funding from the State of Oregon's Early Learning Division whose mission it is *"to support all of Oregon's young children and.families to learn and thrive. We value equi v. making a positive impact for children and .families, dedication, integrity and collective wisdom to ben /it Oregon children and families* ".

Our local Hub aligns with the State in its daily operations by working as an integrated team focused on: Child Care, Early Learning Programs and Cross Systems Integration, Policy and Research, and Equity.

A primary strategy of our Hub is to strengthen the comprehensive Family Resource Coordination system that places Family Resource Coordinators in targeted Health Equity Zones to create optimal access to quality programming. Health Equity Zones in Clackamas County include:

1. Canby
2. Molalla
3. Estacada

Program Goals

The Family Resource Coordinator (FRC) is responsible for coordinating resources and services for families with children ages 0-6 prioritizing those who experience barriers to school success, in order to meet comprehensive Kindergarten Readiness goals including cognitive, language/literacy, social/emotional, behavioral, motor skills, health and well-being. The FRC operates in a specified Health Equity Zone to receive, coordinate, and expedite service referrals for families and help them navigate healthcare, education, and other human service systems. The FRC follows-up with families and service providers to ensure timely access and assure that services have effectively met mutually identified needs.

FRC primary tasks and goals Work include:

1. Being knowledgeable about early childhood development, childhood trauma, Adverse Childhood Experiences (ACEs), transitions, kindergarten readiness, impact of social determinants of health, and other risk factors, as well as the available service/referral options to meet each family's needs.
2. Building formal agreements with other family service providers, such as medical providers, educators, home visitors, school counselors, peer mentors, OHS Case Workers, parent coaches, and others to facilitate seamless referral and access to these services for families.
3. Accepting referrals from parents, school districts, early childhood providers, health providers, human and social service providers, and other child-serving entities.
4. Meeting with referred families to establish a menu of mutually agreed upon service and referral priorities.
5. Monitoring progress and timely follow-up with families to eliminate barriers to accessing recommended services.

6. Facilitating family's access to appropriate health and early childhood systems of screening and assessment (child development, medical, dental, mental health including childhood trauma and toxic stress, kindergarten readiness, and risk factors, etc.).
7. Utilizing Early Learning Hub required database platform to enter and track all client data, contacts, referrals and outcomes, on a continual basis, as work with clients occurs.
8. Participating in multi-specialist staffing sessions for struggling families with multiple destabilizing problems and utilizing multi-specialist teams such as Teacher Assistance Teams and Youth Services Teams.
9. Document comprehensive information about community resources through networks, databases, and partnership opportunities. Utilize and teach families to use Information & Referral tools such as 211, BabyLink, Help Me Grow, and Child Care Resource & Referral. Develop a menu of frequently needed services including, but not limited to basic needs, support groups, vocational development, parents supports and education, mentors, tutors, and social/emotional counseling and support
10. Submit monthly and quarterly reports and invoices as requested via the Clackamas County required reporting database and/or paper reports as requested.

EXHIBIT A-2

Work Plan and Quarterly Report

Clackamas County Children, Family & Community Connections Division
Early Learning Hub of Clackamas County
Work Plan and Quarterly Report

Provider: Todos Juntos
Program: Family Resource Coordination
Quarter:
Reporting Period: October 1, 2021-– December 31, 2022

Hub Goals:

1. Aligned, coordinated, and family-centered early childhood system
2. Children are supported to enter school ready to succeed
3. Families are healthy, stable and attached

Activities/Outputs	Intermediate Outcomes/Measurement Tool		Oct-Dec 2021	Jan-Mar 2022	Apr-Jun 2022	Jul-Sep 2022	Oct-Dec 2022			
By Dec 31, 2022, 200 Families with children (0-6) will be referred and connected to holistic services that promote family stability, healthy child development, and school readiness.	**85% of families** are referred to school staff, family advocates, home visitors, early childhood specialists, behavioral health, and employment specialists.	# Families referred								
		# Families Successfully Connected								
	85% of families will complete early childhood screening and assessments (Developmental, medical, dental, vision, hearing, etc).	# Families referred for screening/ assessments								
		# Families completing screening/ assessments								
	85% of families will be referred to a pediatrician, establish a medical/dental home, insurance enrollment support, and will be offered other health services that promote resiliency and increase protective factors.	# Families referred								
		# Families Successfully Connected								
By Dec 31, 2022, Program participants will receive a minimum of **4** contacts, one of which will be face to face. *Contact is defined as*: face to face, phone call, email, or texting.	**85% of families** will follow through with mutually agreed upon referrals: assessments, treatment options, and family requested supports.	# Families Served								
		# Successful Follow Through on Plans								
By Dec 31, 2022, 150 families will be educated to use Information and Referrals systems i.e. 211info, BabyLink, CCR&R, TriMet Ride, IMATCH, Help Me Grow, etc.	**85% of parents** report that they know how to use I&R systems	# Families Served								
		# Families that report knowing how to use I&R services								
By Dec 31, 2022, all parents served by FRC will receive information on school/ kindergarten readiness, transition to school, literacy, and social/emotional development.	**100%** of families served by FRC will receive kindergarten readiness, successful transitions, literacy, and social emotional development information.	# Families Served								
List Schools, Districts, Community Based Organizations, medical providers, etc. that participated in planning/implementation/ongoing support and referrals of FRC work:										
List community meetings attended during the reporting period:										

Children, Family and Community Connections Division
Early Learning Hub of Clackamas County
Family Resource Coordination
Work Plan 2021-2022
Comments and Narrative

Provider/ Location:
Quarter:

1. Provide detailed information to explain the numbers and activities reported in the work plan above.

    a. General project information:

    b. Professional Development Activities:

    c. Family Focused Activities:

    d. Child Focused Activities:

2. What are your **successes** this quarter, and what are some of the most impactful practices that your organization has implemented as a result of this project?

3. What **challenges** have you experienced this quarter?

    Family Success Stories:

FRC Reporting Requirements

Monthly report, general ledger and reimbursement request

- No later than the 15th of every month
- Reports go to: Dani Stamm Thomas dstammthomas@clackamas.us
- All reports need to CC: Chelsea Hamilton Chamilton@clackamas.us and Stephanie Radford SRadford@clackamas.us

Quarterly Report, Client Satisfaction Surveys and Demographic Data Forms due:

- Oct-Dec **Due January 15, 2022**
- Jan-Mar **Due April 16, 2022**
- April-June **Due July 16, 2022**
- July-Sept **Due October 15, 2022**
- Oct-Dec **Due January 15, 2023**

Client Satisfaction Surveys

Clackamas County's initiative to measure client satisfaction with direct services provided or funded by the county (if applicable).

Exhibit B: Budget

Exhibit B: Budget

Contractor:	Todos Juntos	**FRC**	
Program:	Family Resource Coordinator		
Address:	PO Box 645		
	Canby, OR 97013		
Contact Person:	Shawna Johnson	**Contract #:**	**10425**
Phone Number:		**Contract Term:**	**10/1/21-12/31/22**
E-mail:			

Budget Category	Approved Budget 10/1/21-12/31/22		Total Budget
Personnel			
Family Resource Coordinator .92 fte	$ 57,787.50	$ -	$ 57,787.50
Family Resource Coordinator .6 fte	$ 34,625.00	$ -	$ 34,625.00
Supervision	$ 6,000.00	$ -	$ 6,000.00
Fringe	$ 11,317.44	$ -	$ 11,317.44
			$ -
	$ 109,729.94	**$ -**	**$ 109,729.94**
Administration			
Admin	$ 13,204.07	$ -	$ 13,204.07
	$ 13,204.07	**$ -**	**$ 13,204.07**
Program costs			
Materials/Supplies	$ 3,400.00	$ -	$ 3,400.00
Mileage	$ 3,874.18	$ -	$ 3,874.18
Phone/Internet/Utilities	$ 15,910.81	$ -	$ 15,910.81
Additional (please specify)			
	$ 23,184.99	**$ -**	**$ 23,184.99**
Total Budget	**$ 146,119.00**	**$ -**	**$ 146,119.00**

EXHIBIT C: Quarterly Demographics Report

Quarterly Demographics Report														
Program: FRC Sandy/Estacada	**Provider: Todos Juntos**													
Race/Ethnicity	**Program Participants Served**													
• *Participants should be counted in one category of race/ethnicity.* • *Participants that identify as multi-racial should be counted in that category and the particular racial mix should be included in a narrative.*	First quarter count ALL clients as new													**TOTAL SERVED YTD**
	Oct-Dec 21	Jan-Mar 22			Apr-Jun 22			July-Sep 22			Oct-Dec 22			
		NEW	CONTINUING	CLOSED	NEW	CONTINUING	CLOSED	NEW	CONTINUING	CLOSED	NEW	CONTINUING	CLOSED	
American Indian and Alaska Native														
American Indian														0
Alaska Native														0
Canadian Inuit, Metis or First Nation *(please identify in narrative)*														0
Asian														0
Chinese														0
Vietnamese														0
Korean														0
Laotian														0
Flipino														0
Japanese														0
South Asian														0
Asian Indian														0
Other Asian *(please identify in narrative)*														0
Black/African American														
African American														0
African														0
Caribbean														0
Other Black *(please identify in narrative)*														0
Hispanic or Latino														
Hispanic or Latino Mexican														0
Hispanic or Latino Central American														0
Hispanic or Latino South American														0
Other Hispanic or Latino *(please identify in narrative)*														0
Indigenous Mexican, Central American or South American *(please identify)*														0
Pacific Islander														
Native Hawaiian														0
Guamanian or Chamorro														0
Samoan														0
Other Pacific Islander *(please identify in narrative)*														0
White														0
Slavic														0
Middle Eastern														0
North African														0
Multi-Racial *(please identify in narrative)*														0
Decline to Answer														0
Unknown														0
TOTAL BY RACE/ETHNICITY	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Primary Language														
Cantonese														0
English														0
Russian														0
Spanish														0
Ukranian														0
Vietnamese														0
Other *(list language in narrative)*														0
TOTAL BY LANGUAGE	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Gender Identification														
Female														0
Male														0
Transgender														0
Unknown or Declined to Say														0
TOTAL BY GENDER	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Age														
0-6														0
7-12														0
13-17														0
18-24														0
25-59														0
60+														0
Unknown or Declined														0
TOTAL BY AGE	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Race/Ethnicity ***TOTAL*** *, Gender* ***TOTAL*** *and Age* ***TOTALs*** *should match.*														

Quarterly Demographics Report														
Program: FRC Canby/Molalla	**Provider: Todos Juntos**													
Race/Ethnicity	**Program Participants Served**													
• *Participants should be counted in one category of race/ethnicity.* • *Participants that identify as multi-racial should be counted in that category and the particular racial mix should be included in a narrative.*	First quarter count ALL clients as new													**TOTAL SERVED YTD**
	Oct-Dec 21	Jan-Mar 22			Apr-Jun 22			July-Sep 22			Oct-Dec 22			
		NEW	CONTINUING	CLOSED	NEW	CONTINUING	CLOSED	NEW	CONTINUING	CLOSED	NEW	CONTINUING	CLOSED	
American Indian and Alaska Native														
American Indian														0
Alaska Native														0
Canadian Inuit, Metis or First Nation *(please identify in narrative)*														0
Asian														0
Chinese														0
Vietnamese														0
Korean														0
Laotian														0
Flipino														0
Japanese														0
South Asian														0
Asian Indian														0
Other Asian *(please identify in narrative)*														0
Black/African American														
African American														0
African														0
Caribbean														0
Other Black *(please identify in narrative)*														0
Hispanic or Latino														
Hispanic or Latino Mexican														0
Hispanic or Latino Central American														0
Hispanic or Latino South American														0
Other Hispanic or Latino *(please identify in narrative)*														0
Indigenous Mexican, Central American or South American *(please identify)*														0
Pacific Islander														
Native Hawaiian														0
Guamanian or Chamorro														0
Samoan														0
Other Pacific Islander *(please identify in narrative)*														0
White														0
Slavic														0
Middle Eastern														0
North African														0
Multi-Racial *(please identify in narrative)*														0
Decline to Answer														0
Unknown														0
TOTAL BY RACE/ETHNICITY	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Primary Language														
Cantonese														0
English														0
Russian														0
Spanish														0
Ukranian														0
Vietnamese														0
Other *(list language in narrative)*														0
TOTAL BY LANGUAGE	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Gender Identification														
Female														0
Male														0
Transgender														0
Unknown or Declined to Say														0
TOTAL BY GENDER	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Age														
0-6														0
7-12														0
13-17														0
18-24														0
25-59														0
60+														0
Unknown or Declined														0
TOTAL BY AGE	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
*Race/Ethnicity **TOTAL**, Gender **TOTAL** and Age **TOTALs** should match.*														

EXHIBIT D-1: REIMBURSEMENT REQUEST

Exhibit D-1: REQUEST FOR REIMBURSEMENT

Requests for reimbursement and supporting documentation are due monthly by the 15th of the month, including:

- **Request for Reimbursement with an authorized signature**
- **General Ledger backup to support the requested amount**
- **Monthly Activity Report (Exhibit D-2) showing numbers served and activities conducted during the month of request** ***(The Monthly Activity Report is NOT required on months when quarterly reports are due).***

Contractor:	Totos Juntos	**Contract Number:**	**10425**
Address:	PO Box 645	**Report Period:**	
	Canby, OR		
Contact Person:	Shawna Johnson		
Contact Info:			**FRC**
Term:	10/1/21-12/31/22		

Budget Category	Approved Budget (10/1/21-12/31/22)	Current Draw Request	Previously Requested	Balance
Personnel				
Family Resource Coordinator .92fte	$ 57,787.50	$ -	$ -	$ 57,787.50
Family Resource Coordinator .6fte	$ 34,625.00	$ -	$ -	$ 34,625.00
Supervision	$ 6,000.00	$ -	$ -	$ 6,000.00
Fringe	$ 11,317.44	$ -	$ -	$ 11,317.44
	$ 109,729.94	**$ -**	**$ -**	**$ 109,729.94**
Administration				
Admin	$ 13,204.07	$ -	$ -	$ 13,204.07
	$ 13,204.07	**$ -**	**$ -**	**$ 13,204.07**
Program costs				
Materials/Supplies	$ 3,400.00	$ -	$ -	$ 3,400.00
Mileage	$ 3,874.18	$ -	$ -	$ 3,874.18
Phone/Internet/Utilities	$ 15,910.81	$ -	$ -	$ 15,910.81
Additional (please specify)				
		$ -	$ -	$ -
	$ 23,184.99	**$ -**	**$ -**	**$ 23,184.99**
Total Budget	**$ 146,119.00**	**$ -**	**$ -**	**$ 146,119.00**

Clackamas County retains the right to inspect all financial records and other books, documents, papers, plans, records of shipments and payments and writings of Recipient that are pertinent to this Agreement.

CERTIFICATION

By signing this report, I certify to the best of my knowledge and belief that the report is true, complete, and accurate, and represents actual expenditures, disbursements and cash receipts for the purposes and objectives set forth in the terms of the agreement.

EXHIBIT D-2: MONTHLY ACTIVITY REPORT

Agency: Todos Juntos
Funded Service: Family Resource Coordinator
Program Contact:
Month:

This report covers the fiscal year starting ***October 1, 2021 through December 31, 2022.*** *Complete the sections below as they apply to the group(s) targeted for services with this funding as outlined in your Work Plan.*

Submit this report with monthly requests for reimbursement except on months when the quarterly report is submitted.

1. **Total number of participants served during the month with the funding allocated for this programming:**

   Number of children:

   Number of Families:

2. **Activities that were conducted during the month with the funding allocated for this programming:**

3. **Issues related to service delivery and how those issues were addressed.**

Person(s) completing this form:
Date:

Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

December 2, 2021

Board of County of Commissioners
Clackamas County

Members of the Board:

Approval of an Intergovernmental Agreement with the City of Gladstone
Grant funds of $90,000 through Community Development Block Grant.
No County General Funds

Purpose/ Outcome	Signature approval of an Intergovernmental Agreement to fund construction of up to 11 ADA ramps and sidewalk crossings.
Dollar Amount and Fiscal Impact	Community Development Block Grant funds (CDBG) of $ 90,000: CDBG Funds as a grant $ 20,000: City of Gladstone Funds $ 110,000: Total estimated project costs
Funding Source	U.S. Department of Housing and Urban Development CDBG funds **No County General Funds** are included in this Agreement
Duration	Upon signature to June 30, 2022
Previous Board Action/ Review	BCC Public Hearing on April 8, 2021. May 6, 2021 BCC Approval of the 2021 Action Plan which included $90,000 for the City of Gladstone ADA Ramps Improvements Project.
Strategic Plan Alignment	Increase self-sufficiency for our clients. Ensure safe, healthy and secure communities.
County Review	The Intergovernmental Agreement was reviewed and approved by County Counsel AN on 11/15/2021.
Procurement Review	1. Was the ítem processed through Procurement? *yes* ☐ *no* X 2. Working with Finance Grants, Community Development Division distributed a Notice of Funding Opportunity (NOFO)
Contact Person	Mark Sirois, Manager - Community Development: 503-655-8591
Contract No.	H3S# 10391

BACKGROUND: The Community Development Division of the Health, Housing and Human Services Department requests the approval of an Intergovernmental Agreement for pedestrian and public safety improvements in the City of Gladstone in Clackamas County, OR. In 2019 the City of Gladstone applied for Community Development Block Grant (CDBG) funding to improve connecting streets owned by the city.

PROJECT OVERVIEW: The work to be performed will be for the reconstruction of roadway surface of up to 11 sidewalk crossing ramps to improve the pedestrian safety and improve mobility for persons with disabilities. This Agreement further provides for demolition of old surfaces, adding new curbs and sidewalks, grading for new American's With Disabilities Act (ADA) ramps and storm water conveyance systems.

RECOMMENDATION: We recommend signature approval of this Intergovernmental Agreement

Respectfully submitted,

Rodney Cook Type text here

Rodney A. Cook, Director
Health, Housing, and Human Services

INTERGOVERNMENTAL AGREEMENT
BETWEEN CLACKAMAS COUNTY
AND THE CITY OF GLADSTONE

#10391

THIS AGREEMENT (this "Agreement") is entered into and between Clackamas County ("County"), a political subdivision of the State of Oregon, and the City of Gladstone ("City"), an Oregon municipal corporation, collectively referred to as the "Parties" and each a "Party."

RECITALS

Oregon Revised Statutes Chapter 190.010 confers authority upon local governments to enter into agreements for the performance of any and all functions and activities that a party to the agreement, its officers or agencies have authority to perform.

The County, by and through its Community Development division, and City intend to engage in a project (the "Project") for the construction of up to 11 sidewalk crossing ramps to improve pedestrian safety and improve mobility for persons with disabilities.

The Project meets the U.S. Department of Housing and Urban Development Office ("HUD") requirements for a National Objective, by using federal Community Development Block Grant ("CDBG") funds to remove architectural barriers in the City of Gladstone in low-to-moderate income benefit areas. The County agrees to grant $90,000 for the Project with CDBG funds, and the City agrees to provide a minimum 20% match (estimated to be $20,000), together with all additional Project costs in excess of the CDBG funds granted by the County.

The County will be responsible for bidding, negotiating, and managing any public contracts with third parties necessary to complete the Project. The City will coordinate with County and any third party the County contracts with to complete the Project. The Project is named the City of Gladstone ADA Ramps and Sidewalks Improvements Projects.

In consideration of the mutual promises set forth below and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereby agree as follows:

TERMS

1. **Term.** This Agreement shall be effective upon execution by both parties and unless terminated as set forth herein, shall expire upon the completion of each and every obligation of the Parties set forth herein, or June 30, 2022, whichever is sooner.
2. **Project.** The Project will be for the construction of 11 sidewalk ramps in Gladstone, Oregon, Clackamas County and will be in various neighborhoods divided by Gloucester and Dartmouth Streets as identified in Exhibit B-1. The construction the County will contract for on the Project includes demolition and removal of existing curbs and sidewalk, installing new concrete, and asphalt patching all done in accordance with applicable ADA requirements.
3. **Scope of Work.** The parties agree to perform the services and other tasks identified as set forth in the Scope of Work attached hereto as Exhibit A.

4. **Consideration.** The County will grant CDBG funds toward the Project in an amount not to exceed Ninety Thousand Dollars ($90,000.00) ("CDBG Funds"). The CDBG Funds will be paid directly by the County to contractors hired by County ("Contractor") to complete the Project upon full execution of a construction contract.

   The City will be responsible for a minimum 20% match of the total CDBG Funds, estimated to be $20,000.

   The Project is estimated to cost $110,000.00. In the event the Project will cost more than the estimated $110,000.00, the City agrees to provide an additional $40,000 (in addition to the $20,000 match) towards the Project for a total Project cost of $150,000. Project costs include, but are not limited to construction costs permitted under the contract with the Contractor to complete the Project as well as approved change orders. Project costs do not include architectural and engineering costs that the City will provide pursuant to the City's responsibilities set forth in Exhibit A.

   If, following receipt of construction bid proposals as part of the County's public bid process, either party determines the Project cannot be completed for $150,000.00, the County and City agree to negotiate, in good faith, a possible modification of the Project or this Agreement to accommodate funding limitations. If the parties are unable to reach an agreement as to a modified Project or amendment to the Agreement, this Agreement shall terminate, the parties shall bear their own costs incurred as of the date of termination, and the parties shall have no further obligations regarding this Agreement.

5. **Payment.** The County shall require the Contractor to submit monthly invoices jointly to the City and County for work performed to complete the Project. The invoices shall include the total amount billed to date prior to the current invoice and shall describe all work performed with particularity, by whom it was performed, and shall itemize and explain all expenses for which reimbursement is claimed.

   Payments shall be made by the County to the Contractor directly following the County's review and approval of invoices submitted. County shall make payment(s) to the Contractor in the time and manner set forth in the construction contract with Contractor. The CDBG Funds will be used first to pay the Contractor. The City funds will be used second to pay the Contractor. Once the County has expended all of the CDBG Funds allocated for the Project, the City will pay County additional amounts necessary to complete the Project on a reimbursement basis as follows: County will submit monthly invoices for amounts paid to the Contractor, and the City shall make payment to County within twenty one (21) days of receipt of each invoice. The City will reimburse County for all amounts owed to the Contractor in excess of the CDBG Funds provided by County under this Agreement up to a maximum of $60,000. Payment shall be made to County at the following address:

   Clackamas County

   Public Services Building-Department of Finance

   2051 Kaen Road, Fourth Fl.

   Oregon City, OR 97045

6. **Representations and Warranties.**
   A. City Representations and Warranties: City represents and warrants to County that City has the power and authority to enter into and perform this Agreement, and this Agreement, when executed and delivered, shall be a valid and binding obligation of City enforceable in accordance with its terms.
   B. County Representations and Warranties: County represents and warrants to City has the power and authority to enter into and perform this Agreement, and this Agreement, when executed and delivered, shall be a valid and binding obligation of County enforceable in accordance with its terms.
   C. The warranties set forth in this section are in addition to, and not in lieu of, any other warranties provided.
7. **Termination.**
   A. Prior to County signing a construction contract with Contractor, either the County or the City may terminate this Agreement for convenience upon thirty (30) days written notice to the other party.
   B. Either the County or the City may terminate this Agreement in the event of a breach of the Agreement by the other Party. Prior to such termination however, the Party seeking the termination shall give the other Party written notice of the breach and of the Party's intent to terminate. If the breaching Party has not entirely cured the breach within fifteen (15) days of deemed or actual receipt of the notice, then the Party giving notice may terminate the Agreement at any time thereafter by giving written notice of termination stating the effective date of the termination. If the default is of such a nature that it cannot be completely remedied within such fifteen (15) day period, this provision shall be complied with if the breaching Party begins correction of the default within the fifteen (15) day period and thereafter proceeds with reasonable diligence and in good faith to effect the remedy as soon as practicable. The Party giving notice shall not be required to give more than one (1) notice for a similar default in any twelve (12) month period.
   C. The County or the City shall not be deemed to have waived any breach of this Agreement by the other Party except by an express waiver in writing. An express written waiver as to one breach shall not be deemed a waiver of any other breach not expressly identified, even though the other breach is of the same nature as that waived.
   D. Either Party may terminate this Agreement in the event that Party fails to receive expenditure authority sufficient to allow it, in the exercise of its reasonable administrative discretion, to continue to make payments for performance of this Agreement, or if federal or state laws, regulations or guidelines are modified or interpreted in such a way that performance under this Agreement is prohibited or either Party is prohibited from paying for such work from the planned funding source.
   E. Any termination of this Agreement shall not prejudice any rights or obligations accrued to the Parties prior to termination.

F. Reservation of Remedies. The termination of this Agreement, regardless of cause, shall not prejudice any rights or obligations accrued to the Parties prior to termination. Each Party shall have all rights and remedies available to it at law, in equity, or under this Agreement.

8. **Indemnification.**

Subject to the limits of the Oregon Constitution and the Oregon Tort Claims Act or successor statute, the County agrees to indemnify, save harmless and defend the Agency, its officers, elected officials, agents and employees from and against all costs, losses, damages, claims or actions and all expenses incidental to the investigation and defense thereof arising out of or based upon damages or injuries to persons or property caused by the negligent or willful acts of the County or its officers, elected officials, owners, employees, agents, or its subcontractors or anyone over which the County has a right to control arising from the performance of this Agreement.

A. Subject to the limits of the Oregon Constitution and the Oregon Tort Claims Act or successor statute, the City agrees to indemnify, save harmless and defend the County, its officers, elected officials, agents and employees from and against all costs, losses, damages, claims or actions and all expenses incidental to the investigation and defense thereof arising out of or based upon damages or injuries to persons or property caused by the negligent or willful acts of the City or its officers, elected officials, owners, employees, agents, or its subcontractors or anyone over which the City has a right to control arising from the performance of this Agreement.

9. **Insurance.** The Parties agree to maintain levels of insurance, or self-insurance, sufficient to satisfy their obligations under this Agreement and all requirements under applicable law. Further, the County agrees that in contracting with Contractor it will ensure that the Contractor has and maintains sufficient levels of insurance or self-insurance to satisfy the Contractor's obligations under any construction contract. The County will also ensure that Contractor has identified the County and the City as additional insureds under any construction contract for this Project.

10. **Notices; Contacts.** Legal notice provided under this Agreement shall be delivered personally, by email or by certified mail to the individuals identified below. Any communication or notice so addressed and mailed shall be deemed to be given upon receipt. Any communication or notice sent by electronic mail to an address indicated herein is deemed to be received 2 hours after the time sent (as recorded on the device from which the sender sent the email), unless the sender receives an automated message that the email has not been delivered. Any communication or notice by personal delivery shall be deemed to be given when actually delivered. Either Party may change the Party contact information, or the invoice or payment addresses by giving prior written notice thereof to the other Party at its then current notice address.

A. Amy Counsil or their designee will act as liaison for the County.

Contact Information:

Clackamas County Community Development Division
2051 Kaen Road, Suite 245
Oregon City, OR 97045

Darren Caniparoli or their designee will act as liaison for the City.

Contact Information:

City of Gladstone
18505 Portland Avenue
Gladstone, OR 97055

11. **General Provisions.**

A. **Oregon Law and Forum.** This Agreement, and all rights, obligations, and disputes arising out of it will be governed by and construed in accordance with the laws of the State of Oregon and the ordinances of Clackamas County without giving effect to the conflict of law provisions thereof. Any claim between County and City that arises from or relates to this Agreement shall be brought and conducted solely and exclusively within the Circuit Court of Clackamas County for the State of Oregon; provided, however, if a claim must be brought in a federal forum, then it shall be brought and conducted solely and exclusively within the United States District Court for the District of Oregon. In no event shall this section be construed as a waiver by the County of any form of defense or immunity, whether sovereign immunity, governmental immunity, immunity based on the Eleventh Amendment to the Constitution of the United States or otherwise, from any claim or from the jurisdiction of any court. Agency, by execution of this Agreement, hereby consents to the in persona jurisdiction of the courts referenced in this section.

B. **Compliance with Applicable Law.** Both Parties shall comply with all applicable local, state and federal ordinances, statutes, laws and regulations. This includes, but is not limited to, compliance with all Federal, State, and local laws prohibiting discrimination of the basis of age, sex, sexual orientation, gender identity, marital status, race, color, religion, national origin, familial status, or the presence of any mental or physical disability, as set forth in ORS Chapter 659A; Section 109 of the Housing and Community Development Act of 1974; Civil Rights Act of 1964, Title VII; Fair Housing Amendments Act of 1988; Executive Order 11063; Executive Order 11246; and Section 3 of the Housing and Urban Development Act of 1968; all as amended; and the regulations promulgated thereunder.
All provisions of law required to be a part of this Agreement, whether listed or otherwise, are hereby integrated and adopted herein. Failure to comply with such obligations is a material breach of this Agreement. City agrees to take all necessary steps, and execute and deliver any and all necessary written instruments, to perform under this Agreement including, but not limited to, executing all additional documentation necessary for County to comply with applicable Federal

requirements. All terms and conditions required under applicable federal law regarding CDBG or use of CDBG Funds are hereby incorporated by this reference herein.

C. **Non-Exclusive Rights and Remedies.** Except as otherwise expressly provided herein, the rights and remedies expressly afforded under the provisions of this Agreement shall not be deemed exclusive, and shall be in addition to and cumulative with any and all rights and remedies otherwise available at law or in equity. The exercise by either Party of any one or more of such remedies shall not preclude the exercise by it, at the same or different times, of any other remedies for the same default or breach, or for any other default or breach, by the other Party.

D. **Access to Records.** City shall retain, maintain, and keep accessible all records relevant to this Agreement ("Records") for a minimum of ten (10) years, following Agreement termination or full performance or any longer period as may be required by applicable law, or until the conclusion of an audit, controversy or litigation arising out of or related to this Agreement, whichever is later. Such Records include, but are not limited to, payroll and financial records pertaining in whole or in part to this Agreement. City shall maintain all financial records in accordance with generally accepted accounting principles. All other Records shall be maintained to the extent necessary to clearly reflect actions taken. During this record retention period, City shall permit the County's authorized representatives' access to the Records at reasonable times and places for purposes of examining and/ or copying.

E. **Debt Limitation.** This Agreement is expressly subject to the limitations of the Oregon Constitution and Oregon Tort Claims Act and is contingent upon appropriation of funds. Any provisions herein that conflict with the above referenced laws are deemed inoperative to that extent.

F. **Severability.** If any provision of this Agreement is found to be unconstitutional, illegal or unenforceable, this Agreement nevertheless shall remain in full force and effect and the offending provision shall be stricken. The Court or other authorized body finding such provision unconstitutional, illegal or unenforceable shall construe this Agreement without such provision to give effect to the maximum extent possible the intentions of the Parties.

G. **Integration, Amendment and Waiver.** Except as otherwise set forth herein, this Agreement constitutes the entire agreement between the Parties on the matter of the Project. There are no understandings, agreements, or representations, oral or written, not specified herein regarding this Agreement. No waiver, consent, modification or change of terms of this Agreement shall bind either Party unless in writing and signed by both Parties and all necessary approvals have been obtained. Such waiver, consent, modification or change, if made, shall be effective only in the specific instance and for the specific purpose given. The failure of either Party to enforce any provision of this Agreement shall not constitute a waiver by such Party of that or any other provision.

H. **Interpretation**. The titles of the sections of this Agreement are inserted for convenience of reference only and shall be disregarded in construing or interpreting any of its provisions.

I. **Independent Contractor**. Each of the Parties hereto shall be deemed an independent contractor for purposes of this Agreement. No representative, agent, employee or contractor of one Party shall be deemed to be a representative, agent, employee or contractor of the other Party for any purpose, except to the extent specifically provided herein. Nothing herein is intended, nor shall it be construed, to create between the Parties any relationship of principal and agent, partnership, joint venture or any similar relationship, and each Party hereby specifically disclaims any such relationship.

J. **No Third-Party Beneficiary.** City and County are the only parties to this Agreement and are the only parties entitled to enforce its terms. Nothing in this Agreement gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly, indirectly or otherwise, to third persons unless such third persons are individually identified by name herein and expressly described as intended beneficiaries of the terms of this Agreement.

K. **Subcontract and Assignment.** City shall not enter into any subcontracts for any of the work required by this Agreement, or assign or transfer any of its interest in this Agreement by operation of law or otherwise, without obtaining prior written approval from the County, which shall be granted or denied in the County's sole and absolute discretion. County's consent to any subcontract shall not relieve City of any of its duties or obligations under this Agreement.

L. **Counterparts.** This Agreement may be executed in several counterparts (electronic or otherwise), each of which shall be an original, all of which shall constitute the same instrument.

M. **Survival.** All provisions in Sections 6, 8, and 11 (A), (B), (C), (D), (E), (F), (G), (H), (J), (M), (O), (Q), (R), (S), (T), (U), (V), (W), (X), and (Y) shall survive the termination of this Agreement, and all other rights and obligations which by their context are intended to survive.

N. **Necessary Acts.** Each Party shall execute and deliver to the others all such further instruments and documents as may be reasonably necessary to carry out this Agreement.

O. **Successors in Interest.** The provisions of this Agreement shall be binding upon and shall inure to the benefit of the parties hereto, and their respective authorized successors and assigns.

P. **Force Majeure.** Neither City nor County shall be held responsible for delay or default caused by events outside of the City or County's reasonable control including, but not limited to, fire, terrorism, riot, acts of God, or war. However, both

parties shall make all reasonable efforts to remove or eliminate such a cause of delay or default and shall upon the cessation of the cause, diligently pursue performance of their obligations under this Agreement.

Q. **Confidentiality.** City acknowledges that it and its employees or agents may, in the course of performing their responsibilities under this Agreement, be exposed to or acquire confidential information. Any and all information of any form obtained by City or its employees or agents in the performance of this Agreement that is marked confidential and that is not subject to disclosure under the Oregon Public Records Laws shall be deemed confidential information of the County ("Confidential Information"). City agrees to hold Confidential Information in strict confidence, using at least the same degree of care that City uses in maintaining the confidentiality of its own confidential information, and not to copy, reproduce, sell, assign, license, market, transfer or otherwise dispose of, give, or disclose Confidential Information to third parties or use Confidential Information for any purpose unless specifically authorized in writing under this Agreement.

R. **Conflict of Interest**. No officer, employee, or agent of City or County who exercises any functions or responsibilities in connection with the planning and carrying out of the Project , or any other person who exercises any functions or responsibilities in connection with the Project, shall have any personal financial interest, direct or indirect, in the use of the funds provided pursuant to this Agreement, and the parties shall take appropriate steps to assure compliance. The Parties will insure that no contractor, subcontractor, contractor's employee or subcontractor's employee has or acquires any interest, direct or indirect, which would conflict in any manner or degree with the performance of their services.

S. **Handicapped Accessibility.** City and County agree that all improvements made under this Agreement shall comply with standards set for facility accessibility by handicapped persons required by the Architectural Barriers Act of 1968, as amended. Design standards for compliance are contained in 24 CFR 8.31-32 and the document entitled Uniform Federal Accessibility Standards published by HUD in April, 1988 as a joint effort with other Federal agencies.

T. **Nonsubstituting for Local Funding.** The CDBG Funds made available under this Agreement shall not be utilized by City to reduce substantially the amount of local financial support for community development activities below the level of such support prior to the availability of funds under this Agreement.

U. **Evaluation.** City agrees to participate with the County in any evaluation Project or performance report, as designed by the County or the appropriate Federal department, and to make available all information required by any such evaluation process.

V. **Audits and Inspections.** City will ensure that the County, the Secretary of HUD, the Comptroller General of the United States, or any of their duly authorized representatives shall have access to all books, accounts, records, reports, files, and

other papers or property pertaining to the funds provided under this Agreement that are in the City's possession and control for the purpose of making surveys, audits, examinations, excerpts, and transcripts for the Project.

W. **Acquisition.** If completion of the Project requires acquisition of any real property the Parties agree to comply with the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 as amended.

X. **Change of Use.** City agrees to comply with applicable change of use provisions contained in 24 CFR 570.505.

Y. **Reversion of Assets.** For any real property under City's control that was acquired or improved in whole or in part for this Project with CDBG Funds in excess of $25,000, City shall ensure said real property is either:

   i. Used to meet one of the National Objectives in 24 CFR 570.208 for the term of this Agreement; or
   ii. Not used to meet on the National Objectives for the term of this Agreement, in which event City shall pay to County an amount equal to the current market value of the property less any portion of the value attributable to expenditures of non-CDBG funds for the acquisition of, or improvement to, the property.

[Signatures on Following Page]

IN WITNESS HEREOF, the Parties have executed this Agreement by the date set forth opposite their names below.

City of Gladstone

City of Gladstone
18505 Portland Avenue
Gladstone, Oregon 97055

Tammy Stempel, Mayor

NOV. 9, 2021
Date

Clackamas County

Commissioner, Tootie Smith, Chair
Commissioner, Sonya Fischer
Commissioner, Paul Savas
Commissioner, Martha Schrader
Commissioner, Mark Shull

Tootie Smith, Chair

Date

County Counsel

Andrew Naylor (via email)
Approved to Form

11/15/2021
Date

Exhibit A

SCOPE OF WORK

City Responsibilities:

A. In addition to those responsibilities listed in the Agreement, the City will also complete the following:

1. The City shall provide all necessary supervisory and administrative support to assist the County with the completion of the Project, including providing all necessary authorizations and approvals, consistent with applicable law, for use of the Property as may be necessary to complete the Project.

2. The City shall obtain any easements or approvals necessary to allow access onto private property through the course of the Project. Acquisition of any easement shall be obtained pursuant to the federal Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, as amended ("URA"). If assistance is needed for URA guidance, the County has a Right-Of-Way Acquisition Specialist.

4. The City shall provide primary authority for the rehabilitation of the Project. This shall include; providing all material specifications to bid the Project, as well as review and approval of the County's Project manual prior to release to the public to obtain bids.

5. The City shall provide oversight for the construction in partnership with the County for the Project. Such services shall be provided at no cost to the County provided, however, that nothing herein shall be construed as creating a contractual relationship between the City and Contractor. The City shall solely be a third party beneficiary under any contract between County and Contractor.

6. The City shall require a permit for all bid items for the Project, prior to the Contractor starting any work on the property.

7. The City shall review and approve all Contractor invoice(s) for the Project, prior to the County's review and approval for payment to the Contractor, through the County Finance Department.

8. The City shall operate and maintain the Project improvements for public purposes for their useful life, subject to the limitations on the expenditure of funds by the City. The City agrees to inform the County in writing prior to making any change in the use of the Project improvements. Should the new use not meet HUD eligibility criteria,

or the Project improvements be sold and converted to a non-qualifying use at any time before expiration of this Agreement, the City agrees to reimburse the County as provided under applicable law including, but not limited to, the requirements of 24 CFR 570.505. In no event will the City's reimbursement obligations be less than the full amount provided under 24 CFR 570.505.

9. The City shall complete and submit a Performance Measures Report following completion of the Project, attached as Exhibit B-1 and incorporated by reference, as applicable.

10. The City shall complete and submit a Matching Funds Report following completion of the Project, attached as Exhibit B-2 and incorporated by reference, as applicable.

11. The City shall complete and submit Community Development Block Grant Annual Performance Report following the completion of the Project, attached as Exhibit B-3 and incorporated by reference, as applicable. Below are the HUD Income Limits for the families of this property and Project:

HUD 2021 Annual Income Limits for the Portland-Vancouver Metropolitan Area								
	1 Person	2 Person	3 Person	4 Person	5 Person	6 Person	7 Person	8 Person
Low Income	$32,250	$36,850	$41,450	$46,050	$49,750	$53,450	$57,150	$60.800
Moderate Income	$51,600	$59,000	$66,350	$73,700	$79,600	$85,500	$91,400	$97,300

County Responsibilities:

B. In addition to the responsibilities listed in Agreement, the County will also complete the following:

1. Consistent with applicable state and local public contracting statutes and rules, the County will bid and contract for construction of the Project and, with the advice of the City, will approve changes, modifications, or amendments as necessary to serve the public interest.

2. The County shall include the City as a third party beneficiary under the construction contract with Contractor for construction of the Project.

3. The County will assign a project coordinator to perform the following duties:

a. Provide project manual with City and County documents and bid the Project;

b. Write and send the intent to award notices for the Project to all bidders;

c. Hire the lowest responsive/ responsible Contractor and prepare documents for the Board of County Commissioners approval;

d. Issue the notice to proceed to Contractor and hold a pre-construction meeting with applicable members;

e. Process payments to Contractor for Project costs;

f. Conduct on-site interviews of workers for Federal Prevailing Wage Rates for Davis-Bacon, HUD Federal Labor Standards Provisions as well as review submitted Payroll Forms for the Project;

g. Collect all HUD required project close-out documents; and

h. Release of retainage to Contractor will occur only after the County and the City approve and sign-off on Project improvements in accordance with applicable law and any contract entered into between County and Contractor.

4. The County agrees to provide and administer available CDBG Funds granted by HUD to finance the Project.

5. The County shall conduct necessary environmental reviews described in 24 CFR 570.604 for compliance with requirements of the CDBG program prior to the start of construction.

6. The County shall provide reasonable and necessary staff for administration of the Project.

C. The County and City agree to jointly review and approve all design, material selection, and contract documents for the Project.

Exhibit B-1

PERFORMANCE MEASURES REPORT

FOR THE PERIOD: JULY 1, 2021 TO JUNE 30, 2022

Project Name: Gladstone ADA Ramps and Sidewalk Improvements Project

The Service Area for this project is contained within Census Tract _____ Block Group __ of the City of Gladstone portion of this Block Group is ____% Low- and Moderate-Income.

Choose all that apply:
# of persons _____with new access to this Public Facility or Infrastructure Improvement
# of persons _____with improved access to Public Facility or Infrastructure Improvement
#of persons _____ with access to this type of Public Facility or Infrastructure Improvement that is No Longer Substandard.

Total Number of persons assisted: _____

See Attached
Project Map Area
(*following page*)

Other benefits to the service area:

_____

_____ _____
Signature Date

_____
Organization

Project Map Area

Exhibit B-2

CDBG PROJECT MATCHING FUNDS REPORT

For reporting to HUD at the end of the year, indicate the specific sources and amounts of matching funds for the City of Gladstone ADA Ramps Improvements Project (ramps in various locations):

FY 2021-22 CDBG Funds	$90,000 (max.)

SOURCES OF LOCAL MATCH: Other Federal (including pass-through funds, e.g. County CDBG, State FEMA, etc.)	
_____	$_____
_____	$_____
_____	$_____

State/Local Governmental Funding (e.g. State Housing Trust Funds, Local Assessment, etc.)	
_____	$_____
_____	$_____
_____	$_____

Private (including recipient) Funding	
Fund Raising/Cash	$_____
Loans	$_____
Building Value or Lease	$_____
Donated Goods	$_____
New Staff Salaries	$_____
Volunteers ($10/hr)	$_____
Volunteer Medical/Legal	$_____
Other	$_____

Prepared By: (Print name)

_____ _____

Signature Date

Exhibit B-3

COMMUNITY DEVELOPMENT BLOCK GRANT
ANNUAL PERFORMANCE REPORT

FOR THE PERIOD: JULY 1, _____ TO JUNE 30, _____

Project Name: Gladstone ADA Ramps Improvements Project

Total Number Assisted (H or P)	Total of Columns C, D, and E	Income Categories			Female Headed Households
		Low/Mod (80% - 51%)	Very Low (50% - 30%)	Extremely Low (<30%)	
(A)	(B)	(C)	(D)	(E)	(F)

Females: _____
Persons with Disabilities: _____

Race Categories		Total #	# Hispanic
		(G)	(H)
(1)	White:		
(2)	Black/African American:		
(3)	Asian:		
(4)	American Indian/Alaskan Native:		
(5)	Native Hawaiian/Other Pacific Islander:		
(6)	American Indian/Alaskan Native & White:		
(7)	Asian & White:		
(8)	Black/African American & White:		
(9)	Am. Indian/Alaskan Native & Black/African Am:		
(10)	Other Multi-Racial:		

_____ _____
Signature Date

_____
Organization

INSTRUCTIONS

Total Number Assisted (Column A):

Enter the actual number of persons (or households) who received assistance. Indicate whether this number represents "households" or "persons" with either (H) or (P) respectively. Each household or person may be counted only once. The number of beneficiaries reported in Column A must reflect the total of the beneficiaries reported in Column G.

Total Low/Mod (<80% MFI) (Column B):

The total number of lower income households or persons being served (total of Columns C, D, and E) should be entered in this column.

Income Categories

Low/Mod (Column C) - The total number of persons or households assisted who have an annual household income of 51% to 80% Median Family Income.

Low (Column D) - The total number of persons or households assisted who have an annual household income of 30% to 50% Median Family Income.

Extremely Low (Column E) - The total number of persons or households assisted who have an annual household income of 30% Median Family Income or less.

Female-Headed Household (Column F)

Enter the number of female-headed households. If "persons" assisted is reported in Column A rather than "households" assisted, leave this column blank.

Race (Rows 1 through 10)

All persons/households served (including persons of Hispanic ethnicity) must indicate Race.

Enter the number of households or persons using the facility or service (Column G) who are the following:

White (Row 1) - A person having origins in any of the original peoples of Europe, North Africa, or the Middle East. This category will generally include persons of Hispanic ethnicity but other categories may be chosen as appropriate.

Black or African American (Row 2) - A person having origins in any of the black racial groups of Africa.

Asian (Row 3) - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent.

American Indian or Alaskan Native Origin (Row 4) - A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliations or community recognition.

Native Hawaiian or Other Pacific Islander (Row 5) – A person having origins in the Hawaiian Islands or other Pacific Islands.

American Indian or Alaska Native **and** White (Row 6)

Asian **and** White (Row 7)

Black or African American **and** White (Row 8)

American Indian or Alaska Native **and** Black or African American (Row 9)

Other Multi-Racial (Row 10) – The balance category will be used to report individuals that are not included in any of the single race categories or in any of the multiple race categories listed above.

Ethnicity – Hispanic (Column H)

Enter the total number of persons or households within each Race Category who indicate origins in Mexico, Puerto Rico, Cuba, Central or South America or other Spanish culture or origin.

Gladstone GIS Map

Legend

- Address Numbers
- Street Names
- Taxlots
- City Limits
- Basemap

Notes

Overview Map

0 200 400 Feet

1: 2,400

The City of Gladstone makes no representations, express or implied, as to the accuracy, completeness and timeliness of the information displayed. This map is not suitable for legal, engineering, surveying or navigation purposes. Notification of any errors is appreciated.

Map created 11/2/2021

City of Gladstone
525 Portland Ave
Gladstone
OR 97027
(503) 656-5225
www.ci.gladstone.or.us

Health, Housing & Human Services
CLACKAMAS COUNTY

Mark Sirois, *Manager*
Pamela Anderson, *Manager*

Community Development Division

September 28, 2021

Darren Caniparoli, Operations Manager
City of Gladstone, Public Works Department
18595 Portland Avenue
Gladstone, Oregon 97027

RE: COMMUNITY DEVELOPMENT BLOCK GRANT (CDBG) AWARD LETTER FOR THE GLADSTONE ADA AND SIDEWALK IMPROVEMENTS PROJECT/ FISCAL YEAR 2021-2022

Dear Mr. Caniparoli:

This letter is to inform you that, subject to the approval of the Clackamas County Board of County Commissioners, the City of Gladstone has been awarded $100,000 of Community Development Block Grant (CDBG) funds for the GLADSTONE ADA AND SIDEWALK IMPROVEMENTS PROJECT. This grant is available immediately. The Agreement between our offices must be fully executed prior to any work being scheduled. This Project is to start within 12 months of the executed agreement. If the construction is not started within 12 months you project is in jeopardy of being cancelled and the funds being relinquished. Below is general project information, ready carefully:

2021 CDBG Award Amount: $100,000
Community Development Administrative Fee: - $ 10,000
Usable CDBG Amount Available for Project: $90,000

The grant is also subject to following provisions:

- Release of funds by the U.S. Department of Housing and Urban Development Office;
- An Agreement (Intergovernmental Agreement) of guidelines must be signed by the City of Gladstone and approved by the Clackamas County Board of Commissioners;
- The County must complete an Environmental Review prior to bidding the project.

I will be your assigned Project Coordinator (971-349-2949) from the start of this project through completion of the work. I am looking forward to working with you on this project.

Sincerely,

Amy Counsil

Amy Counsil, Project Coordinator
Cc: Electronic Project File

Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

December 2, 2021

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of a Revenue Grant Agreement from the Oregon Department of Education Youth Development Division to fund PreventNet Community School Sites in Rural Clackamas County Grant Agreement has a value of $200,000.
No County General funds are involved.

Purpose/Outcome	Grant will fund PreventNet Community School sites in Rural Clackamas County through a sub-agreement with a local non-profit agency. PreventNet will provide prevention-focused team-building activities, case coordination, school engagement activities and drug and alcohol prevention programming targeting middle school students at two PreventNet Community schools in rural areas of Clackamas County, specifically Canby and Molalla.
Dollar Amount and Fiscal Impact	$100,000 Federal Funds (7/1/21-9/30/22) $100,000 Federal Funds (10/1/22-6/30/23) No County General Funds are involved.
Funding Source	Oregon Department of Education – Youth Development Division (YDD) through Federal Awarding Agency: Dept of Health and Human Services Catalog of Federal Award (CFDA) # 93.667
Duration	July 1, 2021 – June 30, 2023
Previous Board Action/Review	Approval to apply: 7/22/21 BCC Issues: 11/30/21
Strategic Plan Alignment	1. Ensure safe, healthy and secure communities
Counsel Review	This Grant amendment has been reviewed and approved by County Counsel on 11/10/21, KR
Procurement Review	Was the item processed through Procurement? No. Revenue Grant Award
Contact Person	Adam Freer 971-533-4929
Contract No.	10463

BACKGROUND:
The Children, Family and Community Connections Division of the Health, Housing & Human Services Department requests the approval of Revenue Grant Agreement from Oregon Department of Education Youth Development Division to fund PreventNet Community schools in Canby and Molalla.

PreventNet Community Schools, established in 2001, improves outcomes for children, youth and their families by creating a web of support amount schools, non-profit agencies, community members, local businesses and local government. PreventNet provides prevention and early intervention services that help youth stay engaged and succeed at school by helping them address poor academic performance, truancy, family management problems, alcohol and other drug use, poverty/homelessness, and negative peer associations.

RECOMMENDATION:
Staff recommends Board approval of this Agreement and authorization for Tootie Smith, Board Chair, to sign.

Respectfully submitted,
Rodney Cook
Rodney A. Cook, Director
Health, Housing & Human Services

STATE OF OREGON
GRANT AGREEMENT

Grant No. 16427

This Grant Agreement ("Grant") is between the State of Oregon acting by and through its Department of Education on behalf of the Youth Development Division ("Agency") and Clackamas County Children, Family and Community Connections Division ("Grantee"), each a "Party" and, together, the "Parties".

SECTION 1: AUTHORITY

Pursuant to ORS 417.847 and Federal Award 2101ORSOSR, Agency is authorized to enter into a grant agreement and provide funding for the purposes described in this Grant.

SECTION 2: PURPOSE

The purpose of this grant is to support prevention and intervention services for youth who are disconnected from school and work. Project Services address risk factors that, if left unaddressed, could lead to more costly outcomes such as lower educational attainment, homelessness, and criminal activity.

SECTION 3: EFFECTIVE DATE AND DURATION

When all Parties have executed this Grant, and all necessary approvals have been obtained ("Executed Date"), this Grant is effective and has a Grant funding start date as of July 1, 2021 ("Effective Date"), and, unless extended or terminated earlier in accordance with its terms, will expire on June 30, 2023.

SECTION 4: GRANT MANAGERS

4.1 Agency's Grant Manager is:

Paul Sell
Youth Development Division (YDD)
255 Capitol Street NE, Salem, OR 97310-0203
Phone Number: 503-508-2225
Email Address: paul.sell@state.or.us

4.2 Grantee's Grant Manager is:

Jessica Duke
2051 Kaen Road, Oregon City, OR 97045
Phone Number: 971-291-8569
Email Address: jduke@clackamas.us

4.3 A Party may designate a new Grant Manager by written notice to the other Party.

SECTION 5: PROJECT ACTIVITIES

Grantee must perform the project activities set forth in Exhibit A (the "Project"), attached hereto and incorporated in this Grant by this reference, for the period beginning on the Effective Date and ending on the expiration date set forth in Section 3 (the "Performance Period").

SECTION 6: GRANT FUNDS

In accordance with the terms and conditions of this Grant, Agency will provide Grantee up to $200,000.00 ("Grant Funds") for the Project. Agency will pay the Grant Funds from monies available through its YDD Other Federal Funds Title XX of the Social Services Act, Social Services Block Grant ("Funding Source").

Funding Source	Funding Cycle	Total
Federal Funds	07/01/2021 – 09/30/2022	$100,000.00
Federal Funds	10/01/2022 – 06/30/2023	$100,000.00
	Total Grant Funds	**$200,000.00**

SECTION 7: DISBURSEMENT GENERALLY

7.1 Disbursement.

7.1.1 Subject to the availability of sufficient moneys in and from the Funding Source based on Agency's reasonable projections of moneys accruing to the Funding Source, Agency will disburse Grant Funds to Grantee for the allowable Project activities described in Exhibit A that are undertaken during the Performance Period.

7.1.2 Grantee must provide to Agency any information or detail regarding the expenditure of Grant Funds required under Exhibit A prior to disbursement or as Agency may request.

7.1.3 Agency will only disburse Grant Funds to Grantee for activities completed or materials produced, that, if required by Exhibit A, are approved by Agency. If Agency determines any completed Project activities or materials produced are not acceptable and any deficiencies are the responsibility of Grantee, Agency will prepare a detailed written description of the deficiencies within 15 days of receipt of the materials or performance of the activity, and will deliver such notice to Grantee. Grantee must correct any deficiencies at no additional cost to Agency within 15 days. Grantee may resubmit a request for disbursement that includes evidence satisfactory to Agency demonstrating deficiencies were corrected.

7.2 Conditions Precedent to Disbursement. Agency's obligation to disburse Grant Funds to Grantee under this Grant is subject to satisfaction of each of the following conditions precedent:

7.2.1 Agency has received sufficient funding, appropriations, expenditure limitation, allotments or other necessary expenditure authorizations to allow Agency, in the exercise of its reasonable administrative discretion, to make the disbursement from the Funding Source;

7.2.2 No default as described in Section 15 has occurred; and

7.2.3 Grantee's representations and warranties set forth in Section 8 are true and correct on the date of disbursement(s) with the same effect as though made on the date of disbursement.

7.2.4 Agency will not disburse any Grant Funds to Grantee, unless Grantee has an approved Work Plan on file at Agency

7.3 No Duplicate Payment. Grantee may use other funds in addition to the Grant Funds to complete the Project; provided, however, the Grantee may not credit or pay any Grant Funds for Project costs that are paid for with other funds and would result in duplicate funding.

7.4 Suspension of Funding and Project. Agency may by written notice to Grantee, temporarily cease funding and require Grantee to stop all, or any part, of the Project dependent upon Grant Funds for a period of up to 180 days after the date of the notice, if Agency has or reasonably projects that it will have insufficient funds from the Funding Source to disburse the full amount of the Grant Funds. Upon receipt of the notice, Grantee must immediately cease all Project activities dependent on Grant Funds, or if that is impossible, must take all necessary steps to minimize the Project activities allocable to Grant Funds.

If Agency subsequently projects that it will have sufficient funds, Agency will notify Grantee that it may resume activities. If sufficient funds do not become available, Grantee and Agency will work together to amend this Grant to revise the amount of Grant Funds and Project activities to reflect the available funds. If sufficient funding does not become available or an amendment is not agreed to within a period of 180 days after issuance of the notice, Agency will either (i) cancel or modify its cessation order by a supplemental written notice or (ii) terminate this Grant as permitted by either the termination at Agency's discretion or for cause provisions of this Grant.

SECTION 8: REPRESENTATIONS AND WARRANTIES

8.1 Organization/Authority. Grantee represents and warrants to Agency that:

8.1.1 Grantee is a unit of local government duly organized and validly existing;

8.1.2 Grantee has all necessary rights, powers and authority under any organizational documents and under Oregon Law to (i) execute this Grant, (ii) incur and perform its obligations under this Grant, and (iii) receive financing, including the Grant Funds, for the Project;

8.1.3 This Grant has been duly executed by Grantee and when executed by Agency, constitutes a legal, valid and binding obligation of Grantee enforceable in accordance with its terms;

8.1.4 If applicable and necessary, the execution and delivery of this Grant by Grantee has been authorized by an ordinance, order or resolution of its governing body, or voter approval, that was adopted in accordance with applicable law and requirements for filing public notices and holding public meetings; and

8.1.5 There is no proceeding pending or threatened against Grantee before any court or governmental authority that if adversely determined would materially adversely affect the Project or the ability of Grantee to carry out the Project.

8.2 **False Claims Act.** Grantee acknowledges the Oregon False Claims Act, ORS 180.750 to 180.785, applies to any "claim" (as defined by ORS 180.750) made by (or caused by) Grantee that pertains to this Grant or to the Project. Grantee certifies that no claim described in the previous sentence is or will be a "false claim" (as defined by ORS 180.750) or an act prohibited by ORS 180.755. Grantee further acknowledges in addition to the remedies under Section 16, if it makes (or causes to be made) a false claim or performs (or causes to be performed) an act prohibited under the Oregon False Claims Act, the Oregon Attorney General may enforce the liabilities and penalties provided by the Oregon False Claims Act against the Grantee.

8.3 **No limitation.** The representations and warranties set forth in this Section are in addition to, and not in lieu of, any other representations or warranties provided by Grantee.

SECTION 9: OWNERSHIP

9.1 **Intellectual Property Definitions.** As used in this Section and elsewhere in this Grant, the following terms have the meanings set forth below:

"Third Party Intellectual Property" means any intellectual property owned by parties other than Grantee or Agency.

"Work Product" means every invention, discovery, work of authorship, trade secret or other tangible or intangible item Grantee is required to create or deliver as part of the Project, and all intellectual property rights therein.

9.2 **Grantee Ownership.** Grantee must deliver copies of all Work Product as directed in Exhibit A. Grantee retains ownership of all Work Product, and grants Agency an irrevocable, non-exclusive, perpetual, royalty-free license to use, to reproduce, to prepare derivative works based upon, to distribute, to perform and to display the Work Product, to authorize others to do the same on Agency's behalf, and to sublicense the Work Product to other entities without restriction.

9.3 **Third Party Ownership.** If the Work Product created by Grantee under this Grant is a derivative work based on Third Party Intellectual Property, or is a compilation that includes Third Party Intellectual Property, Grantee must secure an irrevocable, non-exclusive, perpetual, royalty-free license allowing Agency and other entities the same rights listed above for the pre-existing element of the Third party Intellectual Property employed in the Work Product. If state or federal law requires that Agency or Grantee grant to the United States a license to any intellectual property in the Work Product, or if state or federal law requires Agency or the United States to own the intellectual property in the Work Product, then Grantee must execute such further documents and instruments as Agency may reasonably request in order to make any such grant or to assign ownership in such intellectual property to the United States or Agency.

9.4 **Real Property.** If the Project includes the acquisition, construction, remodel or repair of real property or improvements to real property, Grantee may not sell, transfer, encumber, lease or otherwise dispose of any real property or improvements to real property paid for with Grant Funds for a period of six (6) years after the Effective Date of this Grant without the prior written consent of the Agency.

SECTION 10: CONFIDENTIAL INFORMATION

10.1 Confidential Information Definition. Grantee acknowledges it and its employees or agents may, in the course of performing its responsibilities, be exposed to or acquire information that is: (i) confidential to Agency or Project participants or (ii) the disclosure of which is restricted under federal or state law, including without limitation: (a) personal information, as that term is used in ORS 646A.602(12), (b) social security numbers, and (c) information protected by the federal Family Educational Rights and Privacy Act under 20 USC § 1232g (items (i) and (ii) separately and collectively "Confidential Information").

10.2 Nondisclosure. Grantee agrees to hold Confidential Information as required by any applicable law and in all cases in strict confidence, using at least the same degree of care Grantee uses in maintaining the confidentiality of its own confidential information. Grantee may not copy, reproduce, sell, assign, license, market, transfer or otherwise dispose of, give, or disclose Confidential Information to third parties, or use Confidential Information except as is allowed by law and for the Project activities and Grantee must advise each of its employees and agents of these restrictions. Grantee must assist Agency in identifying and preventing any unauthorized use or disclosure of Confidential Information. Grantee must advise Agency immediately if Grantee learns or has reason to believe any Confidential Information has been, or may be, used or disclosed in violation of the restrictions in this Section. Grantee must, at its expense, cooperate with Agency in seeking injunctive or other equitable relief, in the name of Agency or Grantee, to stop or prevent any use or disclosure of Confidential Information. At Agency's request, Grantee must return or destroy any Confidential Information. If Agency requests Grantee to destroy any Confidential Information, Grantee must provide Agency with written assurance indicating how, when and what information was destroyed.

10.3 Identity Protection Law. Grantee must have and maintain a formal written information security program that provides safeguards to protect Confidential Information from loss, theft, and disclosure to unauthorized persons, as required by the Oregon Consumer Information Protection Act, ORS 646A.600-628. If Grantee or its agents discover or are notified of a potential or actual "Breach of Security", as defined by ORS 646A.602(1)(a), or a failure to comply with the requirements of ORS 646A.600-628, (collectively, "Breach") with respect to Confidential Information, Grantee must promptly but in any event within one calendar day (i) notify the Agency Grant Manager of such Breach and (ii) if the applicable Confidential Information was in the possession of Grantee or its agents at the time of such Breach, Grantee must (a) investigate and remedy the technical causes and technical effects of the Breach and (b) provide Agency with a written root cause analysis of the Breach and the specific steps Grantee will take to prevent the recurrence of the Breach or to ensure the potential Breach will not recur. For the avoidance of doubt, if Agency determines notice is required of any such Breach to any individual(s) or entity(ies), Agency will have sole control over the timing, content, and method of such notice, subject to Grantee's obligations under applicable law.

10.4 Subgrants/Contracts. Grantee must require any subgrantees, contractors or subcontractors under this Grant who are exposed to or acquire Confidential Information to treat and maintain such information in the same manner as is required of Grantee under subsections 10.1 and 10.2 of this Section.

10.5 Background Check. If requested by Agency and permitted by law, Grantee's employees, agents, contractors, subcontractors, and volunteers that perform Project activities must agree to submit to a criminal background check prior to performance of any Project activities or receipt of Confidential Information. Background checks will be performed at Grantee's expense. Based on the results of the background check, Grantee or Agency may refuse or limit (i) the participation of any Grantee employee,

agent, contractor, subgrantee, or volunteer, in Project activities or (ii) access to Agency Personal Information or Grantee premises.

SECTION 11: INDEMNITY/LIABILITY

11.1 **Indemnity.** Grantee must defend, save, hold harmless, and indemnify the State of Oregon and Agency and their officers, employees and agents from and against all claims, suits, actions, losses, damages, liabilities, costs, and expenses of any nature whatsoever, including attorneys' fees, resulting from, arising out of, or relating to the activities of Grantee or its officers, employees, subgrantees, contractors, subcontractors, or agents under this Grant (each of the foregoing individually or collectively a "Claim" for purposes of this Section). If legal limitations apply to the indemnification ability of Grantee, this indemnification must be for the maximum amount of funds available for expenditure, including any available contingency funds, insurance, funds available under ORS 30.260 to 30.300 or other available non-appropriated funds.

11.2 **Defense.** Grantee may have control of the defense and settlement of any Claim subject to this Section. But neither Grantee nor any attorney engaged by Grantee may defend the Claim in the name of the State of Oregon, nor purport to act as legal representative of the State of Oregon or any of its agencies, without first receiving from the Attorney General, in a form and manner determined appropriate by the Attorney General, authority to act as legal counsel for the State of Oregon. Nor may Grantee settle any Claim on behalf of the State of Oregon without the approval of the Attorney General. The State of Oregon may, at its election and expense, assume its own defense and settlement in the event the State of Oregon determines Grantee is prohibited from defending the State of Oregon, or is not adequately defending the State of Oregon's interests, or an important governmental principle is at issue and the State of Oregon desires to assume its own defense. Grantee may not use any Grant Funds to reimburse itself for the defense of or settlement of any Claim.

11.3 **Limitation.** Except as provided in this Section, neither Party will be liable for incidental, consequential, or other indirect damages arising out of or related to this Grant, regardless of whether the damages or other liability is based in contract, tort (including negligence), strict liability, product liability or otherwise.

SECTION 12: INSURANCE

12.1 **Private Insurance.** If Grantee is a private entity, or if any contractors, subcontractors, or subgrantees used to carry out the Project are private entities, Grantee and any private contractors, subcontractors or subgrantees must obtain and maintain insurance covering Agency in the types and amounts indicated in Exhibit B.

12.2 **Public Body Insurance.** If Grantee is a "public body" as defined in ORS 30.260, Grantee agrees to insure any obligations that may arise for Grantee under this Grant, including any indemnity obligations, through (i) the purchase of insurance as indicated in Exhibit B or (ii) the use of self-insurance or assessments paid under ORS 30.282 that is substantially similar to the types and amounts of insurance coverage indicated on Exhibit B, or (iii) a combination of any or all of the foregoing.

12.3 **Real Property.** If the Project includes the construction, remodel or repair of real property or improvements to real property, Grantee must insure the real property and improvements against

liability and risk of direct physical loss, damage or destruction at least to the extent that similar insurance is customarily carried by entities constructing, operating and maintaining similar property or facilities.

SECTION 13: GOVERNING LAW, JURISDICTION

This Grant is governed by and construed in accordance with the laws of the State of Oregon without regard to principles of conflicts of law. Any claim, action, suit or proceeding (collectively "Claim") between Agency or any other agency or department of the State of Oregon, or both, and Grantee that arises from or relates to this Grant must be brought and conducted solely and exclusively within the Circuit Court of Marion County for the State of Oregon; provided, however, if a Claim must be brought in a federal forum, then it will be brought and conducted solely and exclusively within the United States District Court for the District of Oregon. In no event may this Section be construed as a waiver by the State of Oregon of any form of defense or immunity, whether sovereign immunity, governmental immunity, immunity based on the eleventh amendment to the Constitution of the United States or otherwise, to or from any Claim or from the jurisdiction of any court. GRANTEE, BY EXECUTION OF THIS GRANT, HEREBY CONSENTS TO THE PERSONAL JURISDICTION OF SUCH COURTS.

SECTION 14: ALTERNATIVE DISPUTE RESOLUTION

The Parties should attempt in good faith to resolve any dispute arising out of this Grant. This may be done at any management level, including at a level higher than persons directly responsible for administration of the Grant. In addition, the Parties may agree to utilize a jointly selected mediator or arbitrator (for non-binding arbitration) to resolve the dispute short of litigation. Each Party will bear its own costs incurred for any mediation or non-binding arbitration.

SECTION 15: DEFAULT

15.1 Grantee. Grantee will be in default under this Grant upon the occurrence of any of the following events:

15.1.1 Grantee fails to use the Grant Funds for the intended purpose described in Exhibit A or otherwise fails to perform, observe or discharge any of its covenants, agreements or obligations under this Grant;

15.1.2 Any representation, warranty or statement made by Grantee in this Grant or in any documents or reports relied upon by Agency to measure the Project, the expenditure of Grant Funds or the performance by Grantee is untrue in any material respect when made; or

15.1.3 A petition, proceeding or case is filed by or against Grantee under any federal or state bankruptcy, insolvency, receivership or other law relating to reorganization, liquidation, dissolution, winding-up or adjustment of debts; in the case of a petition filed against Grantee, Grantee acquiesces to such petition or such petition is not dismissed within 20 calendar days after such filing, or such dismissal is not final or is subject to appeal; or Grantee becomes insolvent or admits its inability to pay its debts as they become due, or Grantee makes an assignment for the benefit of its creditors.

15.1.4 Grantee fails to submit the Project Work Plan, within 45 days of execution of this Grant Agreement as described in Exhibit A.

15.2 **Agency.** Agency will be in default under this Grant if, after 15 days written notice specifying the nature of the default, Agency fails to perform, observe or discharge any of its covenants, agreements, or obligations under this Grant; provided, however, Agency will not be in default if Agency fails to disburse Grant Funds because there is insufficient expenditure authority for, or moneys available from, the Funding Source.

SECTION 16: REMEDIES

16.1 **Agency Remedies.** In the event Grantee is in default under Section 15.1, Agency may, at its option, pursue any or all of the remedies available to it under this Grant and at law or in equity, including, but not limited to: (i) termination of this Grant under Section 18.2, (ii) reducing or withholding payment for Project activities or materials that are deficient or Grantee has failed to complete by any scheduled deadlines, (iii) requiring Grantee to complete, at Grantee's expense, additional activities necessary to satisfy its obligations or meet performance standards under this Grant, (iv) initiation of an action or proceeding for damages, specific performance, or declaratory or injunctive relief, (v) exercise of its right of recovery of overpayments under Section 17 of this Grant or setoff, or both, or (vi) declaring Grantee ineligible for the receipt of future awards from Agency. These remedies are cumulative to the extent the remedies are not inconsistent, and Agency may pursue any remedy or remedies singly, collectively, successively or in any order whatsoever.

16.2 **Grantee Remedies.** In the event Agency is in default under Section 15.2 and whether or not Grantee elects to terminate this Grant, Grantee's sole monetary remedy will be, within any limits set forth in this Grant, reimbursement of Project activities completed and accepted by Agency and authorized expenses incurred, less any claims Agency has against Grantee. In no event will Agency be liable to Grantee for any expenses related to termination of this Grant or for anticipated profits.

SECTION 17: WITHHOLDING FUNDS, RECOVERY

Agency may withhold from disbursements of Grant Funds due to Grantee, or Grantee must return to Agency within 30 days of Agency's written demand:

17.1 Any Grant Funds paid to Grantee under this Grant, or payments made under any other agreement between Agency and Grantee, that exceed the amount to which Grantee is entitled;

17.2 Any Grant Funds received by Grantee that remain unexpended or contractually committed for payment of the Project at the end of the Performance Period;

17.3 Any Grant Funds determined by Agency to be spent for purposes other than allowable Project activities; or

17.4 Any Grant Funds requested by Grantee as payment for deficient activities or materials.

SECTION 18: TERMINATION

18.1 **Mutual.** This Grant may be terminated at any time by mutual written consent of the Parties.

18.2 **By Agency.** Agency may terminate this Grant as follows:

18.2.1 At Agency's discretion, upon 30 days advance written notice to Grantee;

18.2.2 Immediately upon written notice to Grantee, if Agency fails to receive funding, or appropriations, limitations or other expenditure authority at levels sufficient in Agency's reasonable administrative discretion, to perform its obligations under this Grant;

18.2.3 Immediately upon written notice to Grantee, if federal or state laws, rules, regulations or guidelines are modified or interpreted in such a way that Agency's performance under this Grant is prohibited or Agency is prohibited from funding the Grant from the Funding Source; or

18.2.4 Immediately upon written notice to Grantee, if Grantee is in default under this Grant and such default remains uncured 15 days after written notice thereof to Grantee.

18.3 By Grantee. Grantee may terminate this Grant as follows:

18.3.1 If Grantee is a governmental entity, immediately upon written notice to Agency, if Grantee fails to receive funding, or appropriations, limitations or other expenditure authority at levels sufficient to perform its obligations under this Grant.

18.3.2 If Grantee is a governmental entity, immediately upon written notice to Agency, if applicable laws, rules, regulations or guidelines are modified or interpreted in such a way that the Project activities contemplated under this Grant are prohibited by law or Grantee is prohibited from paying for the Project from the Grant Funds or other planned Project funding; or

18.3.3 Immediately upon written notice to Agency, if Agency is in default under this Grant and such default remains uncured 15 days after written notice thereof to Agency.

18.4 Cease Activities. Upon receiving a notice of termination of this Grant, Grantee must immediately cease all activities under this Grant, unless Agency expressly directs otherwise in such notice. Upon termination, Grantee must deliver to Agency all materials or other property that are or would be required to be provided to Agency under this Grant or that are needed to complete the Project activities that would have been performed by Grantee.

SECTION 19: MISCELLANEOUS

19.1 Conflict of Interest. Grantee by signature to this Grant declares and certifies the award of this Grant and the Project activities to be funded by this Grant, create no potential or actual conflict of interest, as defined by ORS Chapter 244, for a director, officer or employee of Grantee.

19.2 Nonappropriation. Agency's obligation to pay any amounts and otherwise perform its duties under this Grant is conditioned upon Agency receiving funding, appropriations, limitations, allotments, or other expenditure authority sufficient to allow Agency, in the exercise of its reasonable administrative discretion, to meet its obligations under this Grant. Nothing in this Grant may be construed as permitting any violation of Article XI, Section 7 of the Oregon Constitution or any other law limiting the activities, liabilities or monetary obligations of Agency.

19.3 Amendments. The terms of this Grant may not be altered, modified, supplemented or otherwise amended, except by written agreement of the Parties.

19.4 **Notice.** Except as otherwise expressly provided in this Grant, any notices to be given under this Grant must be given in writing by email, personal delivery, or postage prepaid mail, to a Party's Grant Manager at the physical address or email address set forth in this Grant, or to such other addresses as either Party may indicate pursuant to this Section. Any notice so addressed and mailed becomes effective five (5) days after mailing. Any notice given by personal delivery becomes effective when actually delivered. Any notice given by email becomes effective upon the sender's receipt of confirmation generated by the recipient's email system that the notice has been received by the recipient's email system.

19.5 **Survival.** All rights and obligations of the Parties under this Grant will cease upon termination of this Grant, other than the rights and obligations arising under Sections 11, 13, 14, 16, 17 and subsection 19.5 hereof and those rights and obligations that by their express terms survive termination of this Grant; provided, however, termination of this Grant will not prejudice any rights or obligations accrued to the Parties under this Grant prior to termination.

19.6 **Severability.** The Parties agree if any term or provision of this Grant is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and provisions will not be affected, and the rights and obligations of the Parties will be construed and enforced as if the Grant did not contain the particular term or provision held to be invalid.

19.7 **Counterparts.** This Grant may be executed in several counterparts, all of which when taken together constitute one agreement, notwithstanding that all Parties are not signatories to the same counterpart. Each copy of the Grant so executed constitutes an original.

19.8 **Compliance with Law.** In connection with their activities under this Grant, the Parties must comply with all applicable federal, state and local laws.

19.9 **Intended Beneficiaries.** Agency and Grantee are the only parties to this Grant and are the only parties entitled to enforce its terms. Nothing in this Grant provides, is intended to provide, or may be construed to provide any direct or indirect benefit or right to third persons unless such third persons are individually identified by name herein and expressly described as intended beneficiaries of this Grant.

19.10 **Assignment and Successors.** Grantee may not assign or transfer its interest in this Grant without the prior written consent of Agency and any attempt by Grantee to assign or transfer its interest in this Grant without such consent will be void and of no force or effect. Agency's consent to Grantee's assignment or transfer of its interest in this Grant will not relieve Grantee of any of its duties or obligations under this Grant. The provisions of this Grant will be binding upon and inure to the benefit of the Parties hereto, and their respective successors and permitted assigns.

19.11 **Contracts and Subgrants.** Grantee may not, without Agency's prior written consent, enter into any contracts or subgrants for any of the Project activities required of Grantee under this Grant. Agency's consent to any contract or subgrant will not relieve Grantee of any of its duties or obligations under this Grant.

19.12 **Time of the Essence.** Time is of the essence in Grantee's performance of the Project activities under this Grant.

19.13 **Records Maintenance and Access.** Grantee must maintain all financial records relating to this Grant in accordance with generally accepted accounting principles. In addition, Grantee must maintain any other records, whether in paper, electronic or other form, pertinent to this Grant in such a manner as to

clearly document Grantee's performance. All financial records and other records, whether in paper, electronic or other form, that are pertinent to this Grant, are collectively referred to as "Records." Grantee acknowledges and agrees Agency and the Oregon Secretary of State's Office and the federal government and their duly authorized representatives will have access to all Records to perform examinations and audits and make excerpts and transcripts. Grantee must retain and keep accessible all Records for a minimum of six (6) years, or such longer period as may be required by applicable law, following termination of this Grant, or until the conclusion of any audit, controversy or litigation arising out of or related to this Grant, whichever date is later.

19.14 **Headings.** The headings and captions to sections of this Grant have been inserted for identification and reference purposes only and may not be used to construe the meaning or to interpret this Grant.

19.15 **Grant Documents.** This Grant consists of the following documents, which are incorporated by this reference and listed in descending order of precedence:

- This Grant less all exhibits
- Exhibit C (Federal Terms and Conditions)
- Exhibit A (the "Project")
- Exhibit B (Insurance)
- Exhibit D (Federal Award Identification)

19.16 **Merger, Waiver.** This Grant and all exhibits and attachments, if any, constitute the entire agreement between the Parties on the subject matter hereof. There are no understandings, agreements, or representations, oral or written, not specified herein regarding this Grant. No waiver or consent under this Grant binds either Party unless in writing and signed by both Parties. Such waiver or consent, if made, is effective only in the specific instance and for the specific purpose given.

[Remainder of page intentionally left blank]

SECTION 20: SIGNATURES

EACH PARTY, BY SIGNATURE OF ITS AUTHORIZED REPRESENTATIVE, HEREBY ACKNOWLEDGES IT HAS READ THIS GRANT, UNDERSTANDS IT, AND AGREES TO BE BOUND BY ITS TERMS AND CONDITIONS. The Parties further agree that by the exchange of this Grant electronically, each has agreed to the use of electronic means, if applicable, instead of the exchange of physical documents and manual signatures. By inserting an electronic or manual signature below, each authorized representative acknowledges that it is their signature, that each intends to execute this Grant, and that their electronic or manual signature should be given full force and effect to create a valid and legally binding agreement.

IN WITNESS WHEREOF, the Parties have executed this Grant as of the dates set forth below.

STATE OF OREGON acting by and through its Department of Education on behalf of the Youth Development Division

By: _____ _____
Senior Contracting Officer Date

Clackamas County Children, Family and Community Connections Division

By: _____ _____
Authorized Signature Date

_____ _____
Printed Name Title

_____
Federal Tax ID Number

Approved as to form: Kathleen Rastetter 11/10/2021

Approved for Legal Sufficiency in accordance with ORS 291.047

By: via email on file at Agency September 16, 2021
Joshua Nasbe, Assistant Attorney General Date

EXHIBIT A
THE PROJECT

SECTION I. BACKGROUND AND GOALS

The YDD functions under the direction and control of the Youth Development Council (YDC) and the Youth Development Director. The YDC (ORS 417.847) provides direction to the YDD (ORS 417.852) and coordinates a unified and aligned system that provides services to youth aged 6 through 24.

YDD community investments support community-based youth development efforts, while prioritizing grants based on indicators of community need, proven practices, and innovative approaches to serving youth. The goals of the Youth Community Investment Grants are to:

- Support efforts to reduce disparities in educational success;
- Improve graduation and completion rates;
- Reduce youth disconnection from school;
- Increase school attendance and readiness;
- Remove barriers to educational engagement, achievement, and success; and
- Encourage multi-sector collaboration to improve outcomes for Youth.

Title XX, Social Service Block Grant ("SSBG") funds also contribute to the YDD goals for this Grant. SSBG specific objectives include:

a. Programs services approved for SSBG funding must be consistent with the overarching goals of the Youth Development Division.

b. Services funded by SSBG are to be directed at one or more of the following federal broad goals:

(1) Achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;

(2) Achieving or maintaining self-sufficiency, including reduction or prevention of dependency;

(3) Preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests; or preserving, rehabilitating or reuniting families;

(4) Preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; and

(5) Securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions.

SECTION II. PROJECT DEFINITIONS

Academic and Educational Supports: Services and strategies used to increase academic achievement and educational engagement.

Culturally Specific Programming: Services and strategies that incorporate cultural knowledge and practices, linguistically specific services, and/or other activities, approaches and resources that are responsive to the culture of individuals or communities served.

Positive Youth Development: Services and strategies that engage youth in an intentional, pro-social approach in a manner that recognizes, utilizes, and enhances youths' strengths while promoting positive outcomes by providing supportive opportunities and fostering positive relationships.

State: The State of Oregon.

Work Plan: Identifies additional details relating to the project activities, outcomes, deliverables, funding, and other components of the work to be performed under the Grant Agreement.

Workforce Readiness: Services and strategies used to provide youth with the knowledge, skills, and abilities required to engage and succeed in the workplace.

Youth: Any person between the ages of 6 and 24.

Youth Advocacy: Services and strategies designed to empower youth and support youth voice in navigating systems, influencing decision making, and raising public awareness.

SECTION III. PROJECT ACTIVITIES AND BUDGET

The Youth Promise initiative is intended to directly support youth ages 6-24 by providing funds for existing programming to a variety of service providers throughout the state. The Youth Promise initiative seeks to help improve and sustain engagement in education and the workforce so that youth may realize their full potential. Program services address protective factors that prevent school disengagement, unhealthy behaviors, and criminal activity.

Agency will disburse Grant Funds only for the costs of Youth Promise Project activities and services that occur, including expenses incurred, during the Performance Period.

Project activities and services may include, but are not limited to:

Academic and Educational Supports

- Educational enrichment opportunities
- Extracurricular activities not otherwise offered through schools or districts
- After school activities including counseling, tutoring, group activities, and mentorship

Culturally Specific Programming

- Services that impart information and knowledge in culturally or linguistically accessible ways
- Programming to address disparities among historically marginalized populations such as racial and ethnic minorities, Tribal Nations, LGBTQ+ youth and others
- Services that incorporate experiential learning based on traditions and practices specific to a culture
- Services delivered by staff who share cultural and linguistic backgrounds with the service population, and/or receive training on how to deliver services to a specific population in a knowledgeable and responsive manner

Positive Youth Development

- Mentoring, tutoring, and coaching
- Mental, social, emotional, and behavioral health supports
- Prosocial activities such as sharing of resources, volunteering, and community service

Workforce Readiness

- College and postsecondary exploration
- STEM and Career/Technical Education activities
- Internships and apprenticeships

Youth Advocacy

- Barrier removal including supports for youth experiencing poverty, houselessness, drug addiction, mental health challenges, and family difficulties
- Trauma-informed supports and activities
- Positive relationship building
- Leadership Councils and other activities that promote youth voice in decision-making processes about youth.

In consultation with Agency staff, Grantee will develop the Project Work Plan. The final Project Work Plan must be approved in writing by Agency.

The Work Plan may only be modified with written Agency approval to: 1) reflect changes needed for the necessary delivery of Project activities; 2) achieve Project outcomes; and 3) use Grant Funds more effectively.

The Project Budget includes the categories of allowable costs and the amount of Grant Funds per category as listed below:

Budget Category	Amount
Direct Services	
Personnel	$163,000.00
Operating	$1,000.00
Supplies and Materials	$1,500.00
Equipment	$ .00
Travel and Transportation	$3,000.00
Direct Supports and Assistance to Youth	$1,500.00
Professional Development and Training	$1,000.00
Total Direct Services	**$171,000.00**
Administrative Costs	$29,000.00
TOTAL GRANT FUNDS	**$200,000.00**

Indirect and Administrative Costs. Grantee may be reimbursed for administrative costs, including indirect costs, as a percentage of the Grant Funds disbursed under this Grant, in an amount up to 15% of overall budget, or Grantee's federally negotiated indirect rate, whichever is greater. The rates described in this paragraph override any other verbal or written rate(s) provided by Agency, including in any notice of award provided by Agency's Electronic Grants Management System ("EGMS").

Budget Adjustments. Grantee may expend Grant Funds that differ from the amounts shown for each category or line item shown in the Project budget included in this Exhibit A (the "Budget") by up to and including 5% without the prior consent of Agency's Grant Manager. Grantee may expend Grant Funds that differ from the amounts shown for each category or line item in the Budget by more than 5% with the prior written approval of Agency's Grant Manager. In no event may the total amount expended for all Project activities paid for with Grant Funds exceed the amount identified in Section 6 of this Grant. Indirect and administrative costs may not exceed the rates or amounts described in this Exhibit A, if applicable, regardless of any adjustments to the Budget. Any adjustments that result in an increase to the amount identified in Section 6 may not be done without an amendment to this Grant.

SECTION IV. ALLOWABLE COSTS

"Allowable Costs" are the activities associated with Grantee's approved Work Plan.

Allowable Costs do not include any of the following:

(1) Any activity or use prohibited by state law or rule or local ordinance;

(2) Campaigning for office or campaigning on behalf of a person who is running for office or who is currently in office;

(3) Religious instruction or recruitment;

(4) Automobile or real estate purchases; and

(5) Any other purpose prohibited by 42 USC 1397d.

SECTION V. ACCESSIBILITY

Worldwide Web Accessibility. If, as part of the Project, Grantee develops data or information that will be displayed or accessed through an Agency public website or world-wide web application (the "Content"), Grantee must comply with Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. 794d), as amended by the Workforce Investment Act of 1998 (P.L. 105-220), and provide individuals with disabilities access to and use of the Content in the website or application that is comparable to the access provided to individuals without disabilities. Grantee must design and format Content that meets at least the following standards, including as the standards are updated or replaced by subsequent versions (collectively, "Mandatory Standard"):

- The Web Accessibility Initiative Accessible Rich Internet Applications Suite (WAI-ARIA) 1.0;
- The World Wide Web Consortium's (W3C's) Web Content Accessibility Guidelines (WCAG) 2.0 Level AA for web content, including as each is updated (Mandatory Standard);
- The web accessibility evaluation tool (WAVE), found at: http://wave.webaim.org/extension/
- Content to be posted on the web must adhere to: https://www.webaccessibility.com/best_practices.php
- PDF files must comply with: http://webaim.org/techniques/acrobat/
- Word files must comply with: http://webaim.org/techniques/word/
- PPT files must comply with: http://webaim.org/techniques/powerpoint/
- Excel files must comply with: https://www.webaccessibility.com/best_practices.php?technology_platform_id=215

Testing. Grantee must test all Content prior to submission to Agency to ensure it meets the Mandatory Standard. Agency will test the web or application to validate the Content meets the Mandatory Standards, including a manual validation review of the Content against the current W3 Checklist for Web Content Accessibility (link included for reference: https://www.w3.org/TR/1999/WAI-WEBCONTENT-19990505/full-checklist.pdf). If the Content fails the testing, Agency will notify Grantee and Grantee must remedy any deficiencies as provided in Section 7.1.3 of this Grant. If Agency determines that previously accepted Content does not meet the Mandatory Standard, Agency may issue a written notice to Grantee to remove the Content. Grantee shall remove Content identified in any such notice within 3 calendar days and take other corrective action specified in the notice.

SECTION VI. PROJECT MONITORING

Grantee will participate in and assist with monitoring visits by the Agency Grant Manager, or Agency's designee. Monitoring visits, scheduled or unannounced, may occur during program operational hours when youth may be present and may include, but are not limited to, interviews with Program youth and staff, and review of Program records.

SECTION VII. REPORTING REQUIREMENTS

Grantee shall submit the Project Work Plan in the form prescribed by the Agency within 45 days of execution of this Agreement to avoid being in Default. Agency will not disburse any Grant Funds to Grantee unless Grantee has the approved Work Plan on file.

Grantee will submit on a quarterly basis the following reports (collectively "Quarterly Reports") to the Agency's Grant Manager identified in Section 4.1, in the format and template prescribed by the Agency's Grant Manager:

- Narrative Report that provides a description of activities, challenges, successes, progress, and promising practices during the respective quarter.
- Data Report that captures information such as demographic and output data (individual level and aggregate level, as needed).
- Expenditure Report that summarizes the Project's quarterly expenses.

The Grantee shall submit the Quarterly Reports on a quarterly basis to Agency's Grant Manager on the following dates:

Quarter	Reporting Period	Report Due Date
Q1	July 1, 2021 – September 30, 2021	By January 17, 2022
Q2	October 1, 2021 – December 31, 2021	By January 17, 2022
Q3	January 1, 2022 – March 31, 2022	By April 15, 2022
Q4	April 1, 2022 – June 30, 2022	By July 15, 2022
Q5	July 1, 2022 – September 30, 2022	By October 17, 2022
Q6	October 1, 2022 – December 31, 2022	By January 16, 2023
Q7	January 1, 2023 – March 31, 2023	By April 17, 2023
Q8	April 1, 2023 - June 30, 2023	Within 30 days of Grant expiration date, or the date designated by Agency for report submission.

If the Performance Period begins prior to the Executed Date, any reports for Project activities shown in this Exhibit A as due prior to the Executed Date must be provided to Agency within 30 days of the Executed Date, if not already provided to Agency despite the lack of an executed Grant. Grantee will not be in default for failure to perform any reporting requirements prior to the Executed Date.

Grantee shall supply any additional related reports, expenditure receipts, and information as Agency may reasonably require.

SECTION VIII. DISBURSEMENT PROVISIONS

Agency will disburse the Grant Funds using EGMS, on a monthly basis upon receipt of Grantee's request(s) for disbursement.

With each request for disbursement and using Agency template, Grantee must submit an expenditure report via email or electronic means as specified by Agency's Grant Manager identified in Section 4.

EXHIBIT B
INSURANCE

INSURANCE REQUIREMENTS

Grantee must obtain at Grantee's expense, and require its first tier contractors and subgrantees, if any, to obtain the insurance specified in this exhibit prior to performing under this Grant, and must maintain it in full force and at its own expense throughout the duration of this Grant, as required by any extended reporting period or tail coverage requirements, and all warranty periods that apply. Grantee must obtain and require its first tier contractors and subgrantees, if any, to obtain the following insurance from insurance companies or entities acceptable to Agency and authorized to transact the business of insurance and issue coverage in Oregon. Coverage must be primary and non-contributory with any other insurance and self-insurance, with the exception of professional liability and workers' compensation. Grantee must pay and require its first tier contractors and subgrantees to pay, if any, for all deductibles, self-insured retention and self-insurance, if any.

WORKERS' COMPENSATION

All employers, including Grantee, that employ subject workers, as defined in ORS 656.027, shall comply with ORS 656.017 and provide workers' compensation insurance coverage for those workers, unless they meet the requirement for an exemption under ORS 656.126(2). Grantee shall require and ensure that each of its subgrantees, contractors, and subcontractors complies with these requirements. If Grantee is a subject employer, as defined in ORS 656.023, Grantee shall also obtain employers' liability insurance coverage with limits not less than $500,000 each accident. If Grantee is an employer subject to any other state's workers' compensation law, Grantee shall provide workers' compensation insurance coverage for its employees as required by applicable workers' compensation laws including employers' liability insurance coverage with limits not less than $500,000, and shall require and ensure that each of its out-of-state subgrantees, contractors, and subcontractors complies with these requirements.

COMMERCIAL GENERAL LIABILITY

☒ **Required**

Commercial general liability insurance covering bodily injury and property damage in a form and with coverage that are satisfactory to Agency. This insurance must include personal and advertising injury liability, products and completed operations, contractual liability coverage for the indemnity provided under this Grant, and have no limitation of coverage to designated premises, project or operation. Coverage must be written on an occurrence basis in an amount of not less than $1,000,000 per occurrence. Annual aggregate limit may not be less than $2,000,000.

AUTOMOBILE LIABILITY INSURANCE

☒ **Required**

Automobile liability insurance covering Grantee's business use including coverage for all owned, non-owned, or hired vehicles with a combined single limit of not less than $1,000,000 for bodily injury and property damage. This coverage may be written in combination with the commercial

general liability insurance (with separate limits for commercial general liability and automobile liability). Use of personal automobile liability insurance coverage may be acceptable if evidence that the policy includes a business use endorsement is provided.

PHYSICAL ABUSE AND MOLESTATION INSURANCE COVERAGE

☒ **Required**

Abuse and molestation insurance in a form and with coverage satisfactory to the State covering damages arising out of actual or threatened physical abuse, mental injury, sexual molestation, negligent: hiring, employment, supervision, investigation, reporting to proper authorities, and retention of any person for whom the Grantee, its contractors, subcontractors or subgrantees ("Covered Entity") is responsible including but not limited to any Covered Entity's employees and volunteers. Policy endorsement's definition of an insured must include the Covered Entity and its employees and volunteers. Coverage must be written on an occurrence basis in an amount of not less than $1,000,000 per occurrence. Any annual aggregate limit may not be less than $2,000,000. Coverage can be provided by a separate policy or as an endorsement to the commercial general liability or professional liability policies. The limits must be exclusive to this required coverage. Incidents related to or arising out of physical abuse, mental injury, or sexual molestation, whether committed by one or more individuals, and irrespective of the number of incidents or injuries or the time period or area over which the incidents or injuries occur, must be treated as a separate occurrence for each victim. Coverage must include the cost of defense and the cost of defense must be provided outside the coverage limit.

NETWORK SECURITY AND PRIVACY LIABILITY

☒ **Required**

Grantee must provide network security and privacy liability insurance for the duration of the Grant and for the period of time in which Grantee (or its business associates, contractors, or subgrantees) maintains, possesses, stores or has access to Agency or client data, whichever is longer, with a combined single limit of no less than $1,000,000 per claim or incident. This insurance must include coverage for third party claims and for losses, thefts, unauthorized disclosures, access or use of Agency or client data (which may include, but is not limited to, Personally Identifiable Information ("PII"), payment card data and Protected Health Information ("PHI")) in any format, including coverage for accidental loss, theft, unauthorized disclosure access or use of Agency data.

PROFESSIONAL LIABILITY (REQUIRED IF GRANTEE EMPLOYS LICENSED PROFESSIONALS)

☒ **Required** ☐ **Not required**

Professional liability insurance covering any damages caused by an error, omission or any negligent acts related to the activities performed under this Grant by the Grantee and Grantee's contractors, subgrantees, agents, officers or employees in an amount not less than $1,000,000 per claim. Annual aggregate limit may not be less than $2,000,000. If coverage is on a claims made basis, then either an extended reporting period of not less than 24 months must be included in the professional liability insurance coverage, or the Grantee must provide tail coverage as stated below.

DIRECTORS, OFFICERS AND ORGANIZATION LIABILITY (FOR NON-PROFITS ONLY)

☒ **Required** ☐ **Not required**

Directors, officers and organization liability insurance covering the Grantee's organization, directors, officers, and trustees actual or alleged errors, omissions, negligent, or wrongful acts, including improper governance, employment practices and financial oversight - including improper oversight and/or use of Grant Funds and donor contributions - with a combined single limit of no less than $1,000,000 per claim.

EXCESS/UMBRELLA INSURANCE

A combination of primary and excess/umbrella insurance may be used to meet the required limits of insurance.

ADDITIONAL INSURED

All liability insurance, except for workers' compensation, professional liability, and network security and privacy liability (if applicable), required under this Grant must include an additional insured endorsement specifying the State of Oregon, its officers, employees and agents as Additional Insureds, including additional insured status with respect to liability arising out of ongoing operations and completed operations, but only with respect to Grantee's activities to be performed under this Grant. Coverage must be primary and non-contributory with any other insurance and self-insurance. The Additional Insured endorsement with respect to liability arising out of Grantee's ongoing operations must be on ISO Form CG 20 10 07 04 or equivalent and the Additional Insured endorsement with respect to completed operations must be on ISO form CG 20 37 04 13 or equivalent.

WAIVER OF SUBROGATION

Grantee waives, and must require its first tier contractors and subgrantees waive, rights of subrogation which Grantee, Grantee's first tier contractors and subgrantees, if any, or any insurer of Grantee may acquire against the Agency or State of Oregon by virtue of the payment of any loss. Grantee must obtain, and require its first tier contractors and subgrantees to obtain, any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the Agency has received a waiver of subrogation endorsement from the Grantee or the Grantee's insurer(s).

TAIL COVERAGE

If any of the required insurance is on a claims made basis and does not include an extended reporting period of at least 24 months, Grantee must maintain, and require its first tier contractors and subgrantees, if any, maintain, either tail coverage or continuous claims made liability coverage, provided the effective date of the continuous claims made coverage is on or before the Effective Date of this Grant, for a minimum of 24 months following the later of (i) Grantee's completion and Agency's acceptance of all Project activities required under this Grant, or, (ii) Agency or Grantee termination of Grant, or, iii) the expiration of all warranty periods provided under this Grant.

CERTIFICATE(S) AND PROOF OF INSURANCE

Grantee must provide to Agency a Certificate(s) of Insurance for all required insurance before performing any Project activities required under this Grant. The Certificate(s) must list the State of Oregon, its officers, employees and agents as a Certificate holder and as an endorsed Additional Insured. The Certificate(s) must also include all required endorsements or copies of the applicable policy language effecting coverage required by this Grant. If excess/umbrella insurance is used to meet the minimum insurance requirement, the Certificate of Insurance must include a list of all policies that fall under the excess/umbrella insurance. As proof of insurance, Agency has the right to request copies of insurance policies and endorsements relating to the insurance requirements in this Grant. Grantee must furnish acceptable insurance certificates to: ode.insurance@ode.state.or.us or by mail to: Attention Procurement Services, Oregon Department of Education, 255 Capitol St NE, Salem OR, 97310 prior to commencing the work.

NOTICE OF CHANGE OR CANCELLATION

Grantee or its insurer must provide at least 30 days' written notice to Agency before cancellation of, material change to, potential exhaustion of aggregate limits of, or non-renewal of the required insurance coverage(s).

INSURANCE REQUIREMENT REVIEW

Grantee agrees to periodic review of insurance requirements by Agency under this Grant, and to provide updated requirements as mutually agreed upon by Grantee and Agency.

STATE ACCEPTANCE

All insurance providers are subject to Agency acceptance. If requested by Agency, Grantee must provide complete copies of insurance policies, endorsements, self-insurance documents and related insurance documents to Agency's representatives responsible for verification of the insurance coverages required under this Exhibit.

EXHIBIT C
FEDERAL TERMS AND CONDITIONS

1. FEDERAL FUNDS

1.1. If specified below, Agency's payments to Grantee under this Grant will be paid in whole or in part by funds received by Agency from the United States Federal Government. If so specified then Grantee, by signing this Grant, certifies neither it nor its employees, contractors, subcontractors or subgrantees who will perform the Project activities are currently employed by an agency or department of the federal government.

Payments ☒ will ☐ will not be made in whole or in part with federal funds.

1.2. In accordance with the State Controller's Oregon Accounting Manual, policy 30.40.00.104, Agency has determined:

☒ Grantee is a subrecipient ☐ Grantee is a contractor ☐ Not applicable

1.3. Catalog of Federal Domestic Assistance (CFDA) #(s) of federal funds to be paid through this Grant: **93.667 Social Services Block Grant**

2. FEDERAL PROVISIONS

2.1. The use of all federal funds paid under this Grant are subject to all applicable federal regulations, including the provisions described below.

2.2. Grantee must ensure that any further distribution or payment of the federal funds paid under this Grant by means of any contract, subgrant, or other agreement between Grantee and another party for the performance of any of the activities of this Grant, includes the requirement that such funds may be used solely in a manner that complies with the provisions of this Grant.

2.3. Grantee must include and incorporate the provisions described below in all contracts and subgrants that may use, in whole or in part, the funds provided by this Grant.

2.4. Grantee must comply, and ensure the compliance by subcontractors or subgrantees, with 41 U.S.C. 4712, Program for Enhancement of Employee Whistleblower Protection. Grantee must inform subrecipients, contractors and employees, in writing, in the predominant language of the workforce, of the employee whistleblower rights and protections under 41 USC § 4712.

In accordance with Appendix II to 2 CFR Part 200 – Grantee is subject to the following provisions, as applicable.

For purposes of these provisions, the following definitions apply:

"Contract" means this Grant or any contract or subgrant funded by this Grant.

"Contractor" and **"Subrecipient"** and **"Non-Federal entity"** mean Grantee or Grantee's contractors or subgrantees, if any.

(A) Contracts for more than the simplified acquisition threshold currently set at $150,000, which is the inflation adjusted amount determined by the Civilian Agency Acquisition Council and the Defense Acquisition Regulations Council (Councils) as authorized by 41 U.S.C. 1908, must address administrative, contractual, or legal remedies in instances where contractors violate or breach contract terms, and provide for such sanctions and penalties as appropriate.

(B) All contracts in excess of $10,000 must address termination for cause and for convenience by the non-Federal entity including the manner by which it will be effected and the basis for settlement.

(C) Equal Employment Opportunity. Except as otherwise provided under 41 CFR Part 60, all contracts that meet the definition of "federally assisted construction contract" in 41 CFR Part 60-1.3 must include the equal opportunity clause provided under 41 CFR 60-1.4(b), in accordance with Executive Order 11246, "Equal Employment Opportunity" (30 FR 12319, 12935, 3 CFR Part, 1964-1965 Comp., p. 339), as amended by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and implementing regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

(D) Davis-Bacon Act, as amended (40 U.S.C. 3141-3148). When required by Federal program legislation, all prime construction contracts in excess of $2,000 awarded by non-Federal entities must include a provision for compliance with the Davis-Bacon Act (40 U.S.C. 3141-3144, and 3146-3148) as supplemented by Department of Labor regulations (29 CFR Part 5, "Labor Standards Provisions Applicable to Contracts Covering Federally Financed and Assisted Construction"). In accordance with the statute, contractors must be required to pay wages to laborers and mechanics at a rate not less than the prevailing wages specified in a wage determination made by the Secretary of Labor. In addition, contractors must be required to pay wages not less than once a week. The non-Federal entity must place a copy of the current prevailing wage determination issued by the Department of Labor in each solicitation. The decision to award a contract or subcontract must be conditioned upon the acceptance of the wage determination. The non-Federal entity must report all suspected or reported violations to the Federal awarding agency. The contracts must also include a provision for compliance with the Copeland "Anti-Kickback" Act (40 U.S.C. 3145), as supplemented by Department of Labor regulations (29 CFR Part 3, "Contractors and Subcontractors on Public Building or Public Work Financed in Whole or in Part by Loans or Grants from the United States"). The Act provides that each contractor or subrecipient must be prohibited from inducing, by any means, any person employed in the construction, completion, or repair of public work, to give up any part of the compensation to which he or she is otherwise entitled. The non-Federal entity must report all suspected or reported violations to the Federal awarding agency.

(E) Contract Work Hours and Safety Standards Act (40 U.S.C. 3701-3708). Where applicable, all contracts awarded by the non-Federal entity in excess of $100,000 that involve the employment of mechanics or laborers must include a provision for compliance with 40 U.S.C. 3702 and 3704, as supplemented by Department of Labor regulations (29 CFR Part 5). Under 40 U.S.C. 3702 of the Act, each contractor must be required to compute the wages of every mechanic and laborer on the basis of a standard work week of 40 hours. Work in excess of the standard work week is permissible provided that the worker is compensated at a rate of not less than one and a half times the basic rate of pay for all hours worked in excess of 40 hours in the work week. The requirements

of 40 U.S.C. 3704 are applicable to construction work and provide that no laborer or mechanic must be required to work in surroundings or under working conditions which are unsanitary, hazardous or dangerous. These requirements do not apply to the purchases of supplies or materials or articles ordinarily available on the open market, or contracts for transportation or transmission of intelligence.

(F) Rights to Inventions Made Under a Contract or Agreement. If the Federal award meets the definition of "funding agreement" under 37 CFR §401.2 (a) and the recipient or subrecipient wishes to enter into a contract with a small business firm or nonprofit organization regarding the substitution of parties, assignment or performance of experimental, developmental, or research work under that "funding agreement," the recipient or subrecipient must comply with the requirements of 37 CFR Part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements," and any implementing regulations issued by the awarding agency.

(G) Clean Air Act (42 U.S.C. 7401-7671q.) and the Federal Water Pollution Control Act (33 U.S.C. 1251-1387), as amended—Contracts and subgrants of amounts in excess of $150,000 must contain a provision that requires the non-Federal award to agree to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401-7671q) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251-1387). Violations must be reported to the Federal awarding agency and the Regional Office of the Environmental Protection Agency (EPA).

(H) Debarment and Suspension (Executive Orders 12549 and 12689)—A contract award (see 2 CFR 180.220) must not be made to parties listed on the government wide exclusions in the System for Award Management (SAM), in accordance with the OMB guidelines at 2 CFR 180 that implement Executive Orders 12549 (3 CFR part 1986 Comp., p. 189) and 12689 (3 CFR part 1989 Comp., p. 235), "Debarment and Suspension." SAM Exclusions contains the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority other than Executive Order 12549.

(I) Byrd Anti-Lobbying Amendment (31 U.S.C. 1352)—Contractors that apply or bid for an award exceeding $100,000 must file the required certification. Each tier certifies to the tier above that it will not and has not used Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 U.S.C. 1352. Each tier must also disclose any lobbying with non-Federal funds that takes place in connection with obtaining any Federal award. Such disclosures are forwarded from tier to tier up to the non-Federal award.

(J) See §200.322 Procurement of recovered materials: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=92b159d8a4db712007ed9d36214ee0ec&mc=true&n=pt2.1.200&r=PART&ty=HTML#se2.1.200_1322.

(K) Audits.

i. Contractor must comply, and require any subcontractor to comply, with applicable audit requirements and responsibilities set forth in this Contract and applicable state or federal law.

ii. If Contractor receives federal awards in excess of $750,000 in a fiscal year, Contractor is subject to audit conducted in accordance with the provisions of 2 CFR part 200, subpart F. Copies of all audits must be submitted to Agency within 30 days of completion.

iii. Contractor must save, protect and hold harmless Agency from the cost of any audits or special investigations performed by the Secretary of State with respect to the funds expended under this Contract. Contractor acknowledges and agrees that any audit costs incurred by Contractor as a result of allegations of fraud, waste or abuse are ineligible for reimbursement under this or any other agreement between Contractor and State.

(L) System for Award Management. Grantee must comply with applicable requirements regarding the System for Award Management (SAM), currently accessible at https://www.sam.gov. This includes applicable requirements regarding registration with SAM, as well as maintaining current information in SAM. The Grantee also must comply with applicable restrictions on subawards ("subgrants") to first-tier subrecipients (first-tier "subgrantees"), including restrictions on subawards to entities that do not acquire and provide (to the Grantee) the unique entity identifier required for SAM registration.

3. ADDITIONAL FEDERAL REQUIREMENTS

Effective December 2014, the Department of Health and Human Services (HHS)-specific implementing regulations of Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards is codified at 45 CFR Part 75.

a. The following provisions apply to all mandatory grant programs:

i. Subpart A – Acronyms and Definitions

ii. Subpart B – General Provisions

iii. Subpart D – Post Federal Award Requirements only portions apply to all:

1. 45 CFR §75.303 – Internal Controls

2. 45 CFR §75.351 through §75.353 – Subrecipient Monitoring and Management.

b. Please see the program specific Supplemental Terms and Conditions as exceptions do apply to some ACF grant programs.

c. Unless otherwise stated, grant recipient and subrecipient must refer to the HHS-specific language in 45 CFR Part 75 rather than 2 CFR Part 200.

Additional federal regulations:

a. 2 CFR Part 25 – Universal Identifier and System for Award Management

b. 2 CFR Part 170 – Reporting Subaward and Executive Compensation Information

c. 2 CFR Part 175 – Award Term for Trafficking in Persons

d. 2 CFR Part 176 – Award Terms for Assistance Agreements that include Funds under the American Recovery and Reinvestment Act of 2009, Public Law 111-5 General Terms and Conditions Mandatory Grant Programs Effective 10-01-2019 Supersedes previous versions. Page 2

e. 2 CFR Part 180 – OMB Guidelines to Agencies on Government-wide Debarment and Suspension (Non Procurement)

f. 2 CFR Part 376 – Nonprocurement Debarment and Suspension

g. 2 CFR Part 382 – Requirements for Drug-Free Workplace (Financial Assistance)

h. 31 U.S.C. §3335, §6501, and §6503 (see also 31 CFR Part 205 – Rules and Procedures for Efficient Federal-State Funds Transfers) – Cash Management Improvement Act

i. 45 CFR Part 16 – Procedures of the Departmental Grant Appeals Board

j. 45 CFR Part 30 – Claims Collection

k. 45 CFR Part 80 – Nondiscrimination Under Programs Receiving Federal Assistance through the Department of Health and Human Services, Effectuation of Title VI of the Civil Rights Act of 1964

l. 45 CFR Part 81 – Practice and Procedure for Hearings Under Part 80 of this Title

m. 45 CFR Part 84 – Nondiscrimination on the Basis of Handicap in Programs and Activities Receiving Federal Financial Assistance

n. 45 CFR Part 86 – Nondiscrimination on the Basis of Sex in Education Programs and Activities Receiving or Benefiting from Federal Financial Assistance

o. 45 CFR Part 87 – Equal Treatment for Faith-Based Organizations

p. 45 CFR Part 91 – Nondiscrimination on the Basis of Age in HHS Programs or Activities Receiving Federal Financial Assistance

q. 45 CFR Part 93 – New Restrictions on Lobbying

r. 45 CFR Part 95 – General Administration – Grant Programs

s. 45 CFR Part 100 – Intergovernmental Review of Department of Health and Human

Human Trafficking Provisions. These awards are subject to the requirements of Section 106(g) of the "Trafficking Victims Protection Act of 2000" (22 U.S.C. 7104). The full text of this requirement is found at http://www.acf.hhs.gov/grants/award-term-andcondition-for-trafficking-in-persons.

Subrecipient Monitoring and Management. According to the Applicability table in 45 CFR §75.101(b)(1), the exceptions described in §75.101(d) and 75.101(e), all mandatory grant programs must comply with the Subrecipient Monitoring and Management requirements described in subpart D, §75.351 through §75.353.

Tangible Property Report (SF-428s), OMB Control No. 4040-0018. Recipients and subrecipients that purchase any tangible personal property (e.g., equipment with a unit cost of $5,000 or more and residual supplies with an aggregate fair market value exceeding $5,000) are required to submit the OMB approved Tangible Personal Property form SF-428. The SF-428 is a

standard form used to collect information related to tangible personal property. All mandatory grant programs are required to submit the SF-428s. Recipients are required to submit the forms on behalf of subrecipients. General Terms and Conditions Mandatory Grant Programs Effective 10-01-2019 Supersedes previous versions. Page 6 a. SF-428. The Cover Page must be submitted along with the other SF-428 Attachments (B, C, and S). b. SF-428 Attachment A. The Federally Owned Property Annual Report is not applicable to ACF grant programs. c. SF-428 Attachment B. The Final/Award Closeout form on Acquired Equipment purchased with Federal Funds is due at the end of a Federal Assistance Award. This form may not apply to some mandatory grant programs. Please see program specific Supplemental Terms and Conditions for applicability. d. SF-428 Attachment C. The Disposition Request form on Acquired Equipment is due at any time other than award closeout. Recipients (and on behalf of subrecipients) may be required to provide compensation to the U.S. Treasury when acquired equipment is sold or retained for use on activities not sponsored by the Federal government. e. SF-428 Attachment S. The Supplemental Sheet may be submitted with the SF-428 Attachment B or C to provide additional information.

Smoking Prohibitions. In accordance with Title XII of Public Law 103-227, the "PROKIDS Act of 1994," smoking may not be permitted in any portion of any indoor facility owned or regularly used for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs whether directly or through State, Territories, local and Tribal governments. Federal programs include grants, cooperative agreements, loans and loan guarantees, subawards, and contracts. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions or facilities and used for inpatient drug and alcohol treatment. The above language must be included in any subawards that contain provisions for children's services and that all subawards shall certify compliance accordingly. Failure to comply with the provisions of this law may result in the imposition of a civil monetary penalty of up to $1,000 per day.

Federal Funds Accountability and Transparency Act (FFATA) Requirements. Awards under these programs are included under the provisions of P.L. 109-282, the "Federal Funds Accountability and Transparency Act of 2006" (FFATA). Under this statute, the grant recipient is required to report information regarding executive compensation and all subawards, contracts, and subcontracts in excess of $25,000 through the Federal Subaward Reporting System (https://www.fsrs.gov/) and in accordance with the terms found in Federal regulations at 2 CFR Part 170, including Appendix A.

Audits. Pass-through entities must ensure that any non-Federal subrecipients that expends Federal funds totaling $750,000 or more during the course of its fiscal year must arrange for a financial audit in compliance with the requirements of 45 CFR Part 75 Subpart F. a. For-profit subrecipients. Unless stated otherwise in regulation or guidance, Subpart F does not apply to for-profit subrecipients. At a minimum, the pass-through entity is responsible for establishing requirements, as necessary, to ensure compliance by forprofit subrecipients. The agreement with the for-profit subrecipient must describe applicable compliance requirements and the for-profit subrecipient's compliance responsibility. Methods to ensure compliance requirements for Federal awards made to for-profit subrecipients may include pre-award audits, monitoring during the agreement, and post-award audits. Please see 45 CFR §75.352 and §75.501(h).

EXHIBIT D
FEDERAL AWARD IDENTIFICATION
(Required by 2 CFR 200.332(a)(1))

(i) Grantee name: *(must match name associated with UEI)*	Clackamas County Children, Family and Community Connections (CFCC) Division
(ii) Grantee's Unique Entity Identifier (UEI):	DUNS: 96992656 SAM:
(iii) Grant period of performance start and end dates:	Start: July 1, 2021 End: June 30. 2021
(iv) Amount of federal funds obligated by this Grant:	$200,000.00
(v) Total* amount of federal funds obligated to Grantee by pass-through entity**, including this Grant:	Detail at Agency
(vi) Name of pass-through entity:	Oregon Department of Education
(vii) Contact information for awarding official of pass-through entity:	Name: Brian Detman Email: Brian.Detman@ode.state.or.us
FEDERAL AWARD	
(i) Federal Award Identification Number (FAIN):	2101ORSOSR
(ii) Federal award date: *(date of award to state by federal agency)*	March 24, 2021
(iii) Grant budget period start and end dates:	Start: July 1, 2021 End: September 30, 2021
(iv) Total* amount of the federal award committed to Grantee by pass-through entity: *(amount of federal funds from this FAIN committed to Grantee)*	Detail at Agency
(v) Federal awarding agency:	Department of Health and Human Services
(vi) Federal award project description:	Title XX of the Social Security Act
(vii) Assistance listings number, title, and amount:	Number: 93.667 Title: Social Services Block Grant Amount: $15,259,494.00
(viii) a. Indirect cost rate for the federal award:	
b. Is the de minimis rate being used per §200.414?	Yes ☐ No ☐
(ix) Is federal award research and development:	Yes ☐ No ☒
FEDERAL AWARD	
(i) Federal Award Identification Number (FAIN):	
(ii) Federal award date: *(date of award to state by federal agency)*	
(iii) Grant budget period start and end dates:	Start: October 1, 2021 End:

(iv) Total* amount of the federal award committed to Grantee by pass-through entity: *(amount of federal funds from this FAIN committed to Grantee)*	$
(v) Federal awarding agency:	Department of Health and Human Services
(vi) Federal award project description:	Title XX of the Social Security Act
(vii) Assistance listings number, title, and amount:	Number: 93.667 Title: Social Services Block Grant Amount: $
(viii) a. Indirect cost rate for the federal award:	
b. Is the de minimis rate being used per §200.414?	Yes ☐ No ☐
(ix) Is federal award research and development:	Yes ☐ No ☒

*The total amount is limited to the current state fiscal year (July 1 to June 30).

**The term "pass-through entity" refers to the State of Oregon, acting through its Department of Education.

Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

December 2, 2021

Board of County Commissioners
Clackamas County

Members of the Board:

Approval to Apply to the Fiscal Year 2022 Health Center Program Budget Period Progress Report (BPR) Non-Competing Continuation (NCC) with Health Resources and Services Administration (HRSA) for Health Center Program (H80) awardees. Award amount will be up to $2,521,317.00. Funding is through HRSA.
No General County Funds are involved.

Purpose/Outcomes	The Budget Period Progress Report Non-Competing Continuation provides an update on the progress of the Health Center Program (H80) award.
Dollar Amount and Fiscal Impact	The maximum agreement value is $2,521,317.00.
Funding Source	Health Resources and Services Administration (HRSA). No County General Funds are involved.
Duration	Effective May 1, 2022 and terminates April 30, 2023
Previous Board Action	No Previous Board Actions have been taken.
Strategic Plan Alignment	1. Improve Community Safety and Health 2. Ensure safe, healthy and secure communities
Counsel Review	Not required, renewal application only
Procurement Review	1. Was the item process through Procurement? Yes ☐ No ☒ 2. This is a direct procurement of a grant.
Contact Person	Deborah Cockrell, Health Center Director – 503-742-5495
Contract No.	

BACKGROUND:
Clackamas County Health Centers Division (CCHCD) of the Health, Housing & Human Services Department requests the approval to apply to the Fiscal Year 2022 Health Center Program Budget Period Progress Report (BPR) Non-Competing Continuation (NCC) with the Health Resources and Services Administration (HRSA). Health Centers is requesting permission to apply for this non-competing continuation of funding. HRSA determined the amount of funding based on the Service Area Competition (HRSA-20-019) application submitted December 23, 2019. The Budget Period Progress Report Non-Competing Continuation provides an update on the progress of the Health Centers Program (H80) award. The fiscal year (FY) 2022 BPR reports on progress made from the beginning of the FY 2021 budget period until the date of the BPR submission; the expected progress for the remainder of the budget period; and any project changes for the FY 2022 budget period.

This Agreement has a maximum value of $2,521,317. It is effective May 1, 2022 and terminates April 30, 2023.

RECOMMENDATION:
Staff recommends the Board approval.

Respectfully submitted,

Rodney Cook

Rodney A. Cook, Director
Health, Housing & Human Services Department

Financial Assistance Application Lifecycle Form

Use this form to track your potential award from conception to submission.
Sections of this form are designed to be completed in collaboration between department program and fiscal staff.

**** CONCEPTION *****

Section I: Funding Opportunity Information - To be completed by Requester

Award type: ☐ Direct Appropriation (no application) ☐ Subrecipient Award ☑ Direct Award

Lead Department & Fund: H3S-Heal;th Ccenters Division

Award Renewal? ☑ Yes ☐ No

If renewal, complete sections 1, 2, & 4 only. If Direct Appropriation, complete page 1 and Dept/Finance signatures only.

If Disaster or Emergency Relief Funding, EOC will need to approve prior to being sent to the BCC

Name of Funding Opportunity: Fiscal Year 2022 Health Center Program Budget Period Progress Report (BPR) Non-Competing Continuation (NCC)

Funding Source: Federal ☑ State ☐ Local ☐

Requestor Information (Name of staff person initiating form): Sarah Jacobson

Requestor Contact Information: 503-742-5303

Department Fiscal Representative: Jennifer Stone

Program Name and prior project # (please specify): MFR 400501; Project 400521202

Brief Description of Project:

The Budget Period Progress Report Non-Competing Continuation (hereafter, BPR) provides an update on the progress of our Health Center Program (H80) award. The fiscal year (FY) 2022 BPR reports on progress made from the beginning of the FY 2021 budget period until the date of the BPR submission; the expected progress for the remainder of the budget period; and any project changes for the FY 2022 budget period.

Name of Funding Agency: Health Resources & Services Administration (HRSA)

Agency's Web Address for funding agency Guidelines and Contact Information:

https://bphc.hrsa.gov/program-opportunities/continuation

OR

Application Packet Attached: ☐ Yes ☐ No

Completed By: Jennifer Stone 11.8.2021 (Date)

**** NOW READY FOR SUBMISSION TO DEPARTMENT FISCAL REPRESENTATIVE *****

Section II: Funding Opportunity Information - To be completed by Department Fiscal Rep

Competitive Application ☐ Non-Competing Application ☑ Other ☐

CFDA(s), if applicable:	93.224	Funding Agency Award Notification Date:	Winter 2022
Announcement Date:	10.10.2021	Announcement/Opportunity #:	N/A
Grant Category/Title:	FY 2022 Noncompeting Continuation	Max Award Value:	$2,521,317.00
Allows Indirect/Rate:	N/A	Match Requirement:	N/A
Application Deadline:	12.6.2021	Other Deadlines:	N/A
Award Start Date:	5.1.2022	Other Deadline Description:	N/A
Award End Date:	4.30.2023		
Completed By:	Jennifer Stone	Program Income Requirement:	N/A
Pre-Application Meeting Schedule:	11.2.2021		

Additional funding sources available to fund this program? Please describe: Program income generated through being a recipient of this grant.

How much General Fund will be used to cover costs in this program, including indirect expenses? N/A

How much Fund Balance will be used to cover costs in this program, including indirect expenses? N/A

Section III: Funding Opportunity Information - **To be completed at Pre-Application Meeting by Dept Program and Fiscal Staff**

Mission/Purpose:

1. How does the grant/funding opportunity support the Department and/or Division's Mission/Purpose/Goals?

2. What, if any, are the community partners who might be better suited to perform this work?

3. What are the objectives of this funding opportunity? How will we meet these objectives?

4. Does the grant/financial assistance fund an existing program? If yes, which program? If no, what is the purpose of the program?

Organizational Capacity:

1. Does the organization have adequate and qualified staff? If no, can staff be hired within the grant/financial assistance funding opportunity timeframe?

2. Are there partnership efforts required? If yes, who are we partnering with and what are their roles and responsibilities?

3.If this is a pilot project, what is the plan for sunsetting the project and/or staff if it does not continue (e.g. making staff positions temporary or limited duration, etc.)?

4. If funded, would this grant/financial assistance create a new program, does the department intend for the program to continue after initial funding is exhausted? If yes, how will the department ensure funding (e.g. request new funding during the budget process, supplanted by a different program, etc.)?

Collaboration

1. List County departments that will collaborate on this award, if any.

Reporting Requirements

1. What are the program reporting requirements for this grant/funding opportunity?

2. How will performance be evaluated? Are we using existing data sources? If yes, what are they and where are they housed? If not, is it feasible to develop a data source within the grant timeframe?

3. What are the fiscal reporting requirements for this funding?

Fiscal

1. Will we realize more benefit than this financial assistance will cost to administer?

2. Are other revenue sources required, available or will be used to fund the program? Have they already been secured? Please name other sources, including General Fund or Fund Balance and amounts.

3. For applications with a match requirement, how much is required (in dollars) and what type of funding will be used to meet it (CGF, In-kind, Local Grant, etc.)?

4. Does this grant/financial assistance cover indirect costs? If yes, is there a rate cap? If no, can additional funds be obtained to support indirect expenses and what are those sources?

Program Approval:

Sarah Jacobson	Sarah Jacobson	
Name (Typed/Printed)	Date	Signature

***** NOW READY FOR PROGRAM MANAGER SUBMISSION TO DIVISION DIRECTOR*****

*****ATTACH ANY CERTIFICATIONS REQUIRED BY THE FUNDING AGENCY. COUNTY FINANCE OR ADMIN WILL SIGN.*****

Section IV: Approvals

DIVISION DIRECTOR (or designee, if applicable)		
Deborah Cockrell	11/9/2021 Nov 9, 2021	
Name (Typed/Printed)	Date	Signature

DEPARTMENT DIRECTOR (or designee, if applicable)		
Rodney Cook	Nov 9, 2021	Mary Rumbaugh Digitally signed by Mary Rumbaugh Date: 2021.11.09 12:15:34 -08'00'
Name (Typed/Printed)	Date	Signature

FINANCE ADMINISTRATION		
Elizabeth Comfort	Nov 9, 2021	Elizabeth Comfort
Name (Typed/Printed)	Date	Signature

EOC COMMAND APPROVAL *(DISASTER OR EMERGENCY RELIEF APPLICATIONS ONLY)*		
N/A	Nov 9, 2021	
Name (Typed/Printed)	Date	Signature

Section V: Board of County Commissioners/County Administration

*(Required for all grant applications. If your grant is awarded, all grant **awards** must be approved by the Board on their weekly consent agenda regardless of amount per local budget law 294.338.)*

For applications less than $150,000:

COUNTY ADMINISTRATOR	Approved: ☐	Denied: ☐
N/A	Nov 9, 2021	
Name (Typed/Printed)	Date	Signature

For applications greater than $150,000 or which otherwise require BCC approval:

BCC Agenda item #: _____ Date: _____

OR

Policy Session Date: _____

_____

County Administration Attestation

County Administration: re-route to department contact when fully approved.
Department: keep original with your grant file.

FAALF-HRSA330

Final Audit Report 2021-11-09

Created:	2021-11-09
By:	Jennifer Johnson (JJohnson@clackamas.us)
Status:	Signed
Transaction ID:	CBJCHBCAABAAm39URKWGb5pA3-RFWomYtBXiUULJsQC_

"FAALF-HRSA330" History

Document digitally presigned by Mary Rumbaugh (maryrum@clackamas.us)
2021-11-09 - 8:15:34 PM GMT- IP address: 198.245.132.3

Document created by Jennifer Johnson (JJohnson@clackamas.us)
2021-11-09 - 11:46:07 PM GMT- IP address: 198.245.132.3

Document emailed to Elizabeth Comfort (ecomfort@clackamas.us) for signature
2021-11-09 - 11:46:47 PM GMT

Email viewed by Elizabeth Comfort (ecomfort@clackamas.us)
2021-11-09 - 11:50:08 PM GMT- IP address: 73.11.9.19

Document e-signed by Elizabeth Comfort (ecomfort@clackamas.us)
Signature Date: 2021-11-09 - 11:50:32 PM GMT - Time Source: server- IP address: 73.11.9.19

Agreement completed.
2021-11-09 - 11:50:32 PM GMT