CLACKAMAS COUNTY

BOARD OF COUNTY COMMISSIONERS
PUBLIC SERVICES BUILDING
2051 KAEN ROAD | OREGON CITY, OR 97045

AGENDA

Thursday, September 5, 2019 - 10:00 AM
BOARD OF COUNTY COMMISSIONERS

Beginning Board Order No. 2019-84

CALL TO ORDER

- Roll Call
- Pledge of Allegiance

I. PRESENTATION *(Following are items of interest to the citizens of the County)*

1. Recognition of the 2019 Outstanding Member Agency Award to Water Environment Services from the Oregon Association of Clean Water Agencies (ACWA) (Todd Loggan, Public & Government Affairs)

II. CITIZEN COMMUNICATION *(The Chair of the Board will call for statements from citizens regarding issues relating to County government. It is the intention that this portion of the agenda shall be limited to items of County business which are properly the object of Board consideration and may not be of a personal nature. Persons wishing to speak shall be allowed to do so after registering on the blue card provided on the table outside of the hearing room prior to the beginning of the meeting. Testimony is limited to three (3) minutes. Comments shall be respectful and courteous to all.)*

III. CONSENT AGENDA *(The following Items are considered to be routine, and therefore will not be allotted individual discussion time on the agenda. Many of these items have been discussed by the Board in Work Sessions. The items on the Consent Agenda will be approved in one motion unless a Board member requests, before the vote on the motion, to have an item considered at its regular place on the agenda.)*

A. Health, Housing & Human Services

1. Approval of Amendment No. 1 to the Intergovernmental Agreement with the State of Oregon acting by and through its Oregon Health Authority for Operation as the Local Public Health Authority for Clackamas County – *Public Health*

2. Approval of a Sub-recipient Agreement with Northwest Housing Alternatives and the Community Development Division for ESG Funding for the Annie Ross Homeless Shelter Services – *Community Development*

3. Approval of a Sub-recipient Agreement with Northwest Housing Alternatives and the Community Development Division for ESG Funding for the Homebased Rapid Re-Housing Services - *Community Development*

4. Approval to Apply for a Grant from Portland General Electric Drive Change Fund to Advance the Electrification of the Elderly & Disabled Transportation Network – *Social Services*

5. Approval to Apply to the Oregon Department of Veterans Affairs for FT 2020 Distribution of Funds – *Social Services*

B. Department of Transportation & Development

1. Board Order No. _____ Accepting and Acknowledging Right of Way and Simultaneously Vacating Schmidt Road

2. Resolution No. _____ Declaring the Public Necessity and Purpose for Acquisition of Rights-of-Way, Easements, and Fee Property for the S Central Point Rd. and S New Era Rd. Intersection Realignment Project and Authorizing Good Faith Negotiations and Condemnation Actions

3. Approval of a Federal Lands Access Program Project Memorandum of Agreement with Western Federal Lands Highway Division for the East Salmon River Road Surface Preservation Project

4. Approval of a Federal Lands Access Program Project Grant Agreement with Western Federal Lands Highway Division for the Lolo Pass Road Stabilization and Surface Preservation Project

5. Approval of a Contract with Kerr Contractors Oregon, Inc., for Realignment of Victory Road at Forsythe Road - *Procurement*

C Elected Officials

1. Approval of Previous Business Meeting Minutes – *BCC*

2. Request by the Clackamas County Sheriff's Office to Enter into the Annual Operating and Financial Plan with the USDA Forest Service for Cooperative Law Enforcement Services in the Mt. Hood National Forest - *CCSO*

D. Disaster Management

1. Approval of an Amended Sub-recipient Agreement with the City of Portland for Purchase and Reimbursement Activities Related to the use of the FY17 US Department of Homeland Security's Urban Area Security Initiative (UASI) Grant Program

E. Community Corrections

1. Approval Intergovernmental Agreement between Clackamas County Community Corrections and City of Happy Valley to Provide Work Crew Services

2. Approval Intergovernmental Agreement between Clackamas County Community Corrections and City of Gladstone to Provide Work Crew Services

F. Human Resources

1. Retroactive Approval of 2018 Agreements with Providence Health Plan for Administrative Services for Clackamas County's Self-Funded Medical Benefits

IV. WATER ENVIRONMENT SERVICES

1. Approval of the Utility Easement Agreement between Water Environment Services and Portland General Electric Company at the Tri-City Water Resource Recovery Facility

2. Approval of an Intergovernmental Agreement between Water Environment Services and Clackamas Community College for Watershed Health Education Field Trips

3. Approval of a Contract with Carollo Engineers for the Willamette Facility Plan - *Procurement*

V. COUNTY ADMINISTRATOR UPDATE

VI. COMMISSIONERS COMMUNICATION

Sue Hildick
Director

Public and Government Affairs
Public Services Building
2051 Kaen Road, Oregon City, OR 97045

September 5, 2019

Board of County Commissioners
Clackamas County

Members of the Board:

2019 Outstanding Member Agency Award for WES from the
Oregon Association of Clean Water Agencies (ACWA)

Purpose/Outcome	To recognize Water Environment Services for receiving the 2019 Outstanding Member Agency Award from the Oregon Association of Clean Water Agencies (ACWA).
Fiscal Impact	None
Funding Source	N/A
Duration	N/A
Previous Action	None
Strategic Plan Alliance	1. Ensure safe, healthy and secure communities 2. Build a strong infrastructure 3. Honor, utilize, promote and invest in our natural resources
Counsel Review	N/A
Contact Person	Todd Loggan, Community Relations Specialist, PGA 503-742-4562 or Ed Nieto, Community Relations Specialist, PGA 503-742-4371

BACKGROUND:
On July 26, Water Environment Services received the 2019 Outstanding Member Agency Award from The Oregon Association of Clean Water Agencies (ACWA). The award is given out annually by ACWA, which has more than 100 member agencies. ACWA provides high value, science-based services to its membership through education, regulatory advocacy, and partnerships for the development of proactive solutions resulting in water resources management that is environmentally, financially and organizationally sustainable.

The annual ACWA award is given to one **Outstanding Member Agency** excelling in any of the areas of pollution prevention, environmental leadership, or innovation in environmental management.

The 2019 Outstanding Member Agency Award was given to WES "for its leadership in pollution prevention and innovation in environmental management, as demonstrated by the recently completed Carli Creek Water Quality Project." ACWA Chair Amy Pepper said, "The Carli Creek Project demonstrates in a big way, the type of multi-objective,

multi-benefit projects ACWA promotes to protect and enhance communities, the environment and water quality with sustainability and resilience in mind."

Since December 18, 2018, the Carli Creek Water Quality Facility has filtered harmful pollutants from stormwater runoff before it reaches Carli Creek and the Clackamas River, which is the drinking water source for more than 360,000 people.

Before WES built the new stormwater infrastructure, runoff carried pollutants from surrounding industrial properties and heavily-traveled roads directly into Carli Creek, and then the Clackamas River, threatening water quality, fish and public health.

WES recognized the potential of the Carli family property to improve river water quality and acquired the former farmland to establish the innovative facility, which now ensures a cleaner Clackamas River, protection for endangered fish species, increased habitat function for birds and aquatic life, and demonstrates that a balance between nature and industry is possible.

WES' new stormwater infrastructure at Carli Creek also supports top Clackamas County priorities, including: building a strong infrastructure; honoring, utilizing and investing in natural resources; and ensuring safe, healthy and secure communities.

RECOMMENDATION:
Staff recommends the Board receive this presentation on WES being honored with the 2019 Outstanding Member Agency Award from The Oregon Association of Clean Water Agencies.

Respectfully submitted,

Sue Hildick
Director, Public and Government Affairs

Health, Housing & Human Services
CLACKAMAS COUNTY

COPY

Richard Swift
Director

September 5, 2019

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of Amendment #01 to the Intergovernmental Agreement with the State of Oregon, acting by and through its Oregon Health Authority for Operation as the Local Public Health Authority for Clackamas County

Purpose/Outcomes	Amendment #01 adds new Program Element (PE) 02 and updates language for PE 42 and PE46.
Dollar Amount and Fiscal Impact	Contract is increased by $124,381, bringing the contract maximum value is $2,526,665.
Funding Source	Funding through the State. No County General Funds are involved.
Duration	Effective upon signature and terminates on June 30, 2021
Previous Board Action	The Board last reviewed and approved this agreement on June 20, 2019, Agenda item 062019-A1
Strategic Plan Alignment	1. Improved Community Safety and Health 2. Ensure safe, healthy and secure communities
Counsel Review	County counsel has reviewed and approved this document on August 21, 2019
Contact Person	Richard Swift, Interim Public Health Director – (503) 655-8479
Contract No.	9329-01

BACKGROUND:
The Clackamas County Public Health Division (CCPHD) of the Health, Housing & Human Services Department requests the approval of Amendment #01 to the Intergovernmental Agreement with State of Oregon, Oregon Health Authority. This Amendment adds Program Element (PE) 02 – Cities Readiness initiative and updates language for PE 42 - Maternal Childs Adolescence Health and PE 46 – Reproductive Health. Amendment #01 also increases the contract by $124,381. bringing the maximum contract value to $$2,526,665.

This contract is effective upon signature and continues through June 30, 2021.

RECOMMENDATION:
Staff recommends the Board approval of this agreement and authorizes Richard Swift, H3S Director to sign on behalf of Clackamas County.

Respectfully submitted,

H3S Deputy Director/FOR

Richard Swift, Director
Health, Housing, and Human Services

Agreement #159803

Oregon Health Authority

FIRST AMENDMENT TO OREGON HEALTH AUTHORITY 2019-2021 INTERGOVERNMENTAL AGREEMENT FOR THE FINANCING OF PUBLIC HEALTH SERVICES

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 First Amendment to Oregon Health Authority 2019-2021 Intergovernmental Agreement for the Financing of Public Health Services, effective July 1, 2019, (as amended the "Agreement"), is between the State of Oregon acting by and through its Oregon Health Authority ("OHA") and Clackamas County, ("LPHA"), the entity designated, pursuant to ORS 431.003, as the Local Public Health Authority for Clackamas County.

RECITALS

WHEREAS, OHA and LPHA wish to modify the Program Element Table as set forth in Exhibit A of the Agreement;

WHEREAS, OHA and LPHA wish to modify the Program Element Descriptions as set forth in Exhibit B of the Agreement;

WHEREAS, OHA and LPHA wish to modify the Fiscal Year 2020 (FY20) Financial Assistance Award set forth in Exhibit C of the Agreement;

WHEREAS, OHA and LPHA wish to modify the Exhibit J information required by 2 CFR Subtitle B with guidance at 2 CFR Part 200;

NOW, THEREFORE, in consideration of the premises, covenants and agreements contained herein and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties hereto agree as follows

AGREEMENT

1. Exhibit A "Definitions", Section 16 "Program Element" is amended to add if new or replace if existing, the following Program Element titles and funding source identifiers as follows:

PE NUMBER AND TITLE • SUB-ELEMENT(S)	FUND TYPE	FEDERAL AGENCY/ GRANT TITLE	CFDA#	HIPAA RELATED (Y/N)	SUB-RECIPIENT (Y/N)
PE 02 Cities Readiness Initiative (CRI) Program	FF	CDC/Public Health Emergency Preparedness	93.069	N	Y
PE 46 Reproductive Health Community Participation & Assurance	FF/GF	DHHS/Family Planning Services	93.217	N	Y

2. Exhibit B Program Element #02 "Cities Readiness Initiative (CRI) Program" is hereby superseded and replaced in its entirety by Attachment A attached hereto and incorporated herein by this reference.

3. Exhibit B Program Element #42 "Maternal, Child and Adolescent Health (MCAH) Services" is hereby superseded and replaced in its entirety by Attachment A attached hereto and incorporated herein by this reference.

4. Exhibit B Program Element #46 "Reproductive Health" is hereby superseded and replaced in its entirety by Attachment A attached hereto and incorporated herein by this reference.

5. Exhibit C entitled "Financial Assistance Award" of the Agreement for FY20 is hereby superseded and replaced in its entirety by Attachment B attached hereto and incorporated herein by this reference. Attachment B must be read in conjunction with Section 3 of Exhibit C.

6. Exhibit J "Information required by 2 CFR Subtitle B with guidance at 2 CFR Part 200" is amended to add to the federal award information datasheet as set forth in Attachment C, attached hereto and incorporated herein by this reference.

7. LPHA represents and warrants to OHA that the representations and warranties of LPHA set forth in Section 2 of Exhibit E of the Agreement are true and correct on the date hereof with the same effect as if made on the date hereof.

8. Capitalized words and phrases used but not defined herein shall have the meanings ascribed thereto in the Agreement.

9. Except as amended hereby, all terms and conditions of the Agreement remain in full force and effect.

10. The parties expressly ratify the Agreement as herein amended.

11. This Amendment may be executed in any number of 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 this Amendment so executed shall constitute an original.

12. This Amendment becomes effective on the date of the last signature below.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment as of the dates set forth below their respective signatures.

13. Signatures.

By: _____

Name: /for/ Lillian Shirley, BSN, MPH, MPA

Title: Public Health Director

Date: _____

CLACKAMAS COUNTY LOCAL PUBLIC HEALTH AUTHORITY

By: _____

Name: Richard Swift,

Title: Director, Health, Housing and Human Services

Date: _____

DEPARTMENT OF JUSTICE – APPROVED FOR LEGAL SUFFICIENCY

Approved by Steven Marlowe, Senior Assistant Attorney General on July 26, 2019. Copy of emailed approval on file at OHA, OC&P.

REVIEWED BY OHA PUBLIC HEALTH ADMINISTRATION

By: _____

Name: Derrick Clark *(or designee)*

Title: Program Support Manager

Date: _____

Health, Housing & Human Services
CLACKAMAS COUNTY

COPY

Richard Swift
Director

September 5, 2019

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of a Sub-recipient Agreement with Northwest Housing Alternatives and the Community Development Division for
ESG Funding for the Annie Ross Homeless Shelter services

Purpose/ Outcome	The Emergency Solutions Grant (ESG) program is designed to: improve existing homeless shelters; provide funds to operate emergency shelters; provide essential social services to homeless individuals and; provide homeless prevention and rapid re-housing assistance.
Dollar Amount and Fiscal Impact	Emergency Solutions Grant (ESG) funds of $40,000 as a grant. No County General Funds are included in this Agreement
Funding Source	U.S. Department of Housing and Urban Development ESG funds
Duration	July 1, 2019 to June 30, 2020
Previous Board Action/ Review	May 2, 2019 approval of the 2019 One-Year Action Plan which included a funding recommendation of $40,000 of ESG funds to be available for NHA.
Strategic Plan Alignment	Increase self-sufficiency for our clients. Ensure safe, healthy and secure communities.
County Review	The Sub-recipient agreement was reviewed and approved by County Counsel on August 13, 2019.
Contact Person	Mark Sirois, Project Coordinator - Community Development: 503-655-8359
Contract No.	H3S 9446

BACKGROUND: The Community Development Division of the Health, Housing and Human Services Department requests the approval of a Sub-recipient Agreement for eligible homeless shelter services expenditures for Northwest Housing Alternatives (NHA) Annie Ross House Homeless Shelter services in Clackamas County, OR. In December of 2016 NHA applied for Emergency Solutions Grant (ESG) funding to provide emergency shelter services in Clackamas County. NHA was awarded 3 years of funding for FY 2017, FY 2018 and FY 2019. Each year a new sub-recipient agreement is signed.

PROJECT OVERVIEW: NHA will provide homeless shelter services including: Safety planning, Advocacy and assistance navigating systems, Case management, Crisis intervention, Information and Referral, Support groups and Counseling. It is expected that the limited funding under this ESG contract will assist approximately 50 homeless families to secure housing during the program year.

RECOMMENDATION: We recommend the approval of this Sub-recipient Agreement and that Richard Swift H3S Director be authorized to sign on behalf of the Board of County Commissioners.

Respectfully submitted,

Patty A. Cook, H3S Deputy Director/For

Richard Swift, Director
Health, Housing Human Services

CLACKAMAS COUNTY, OREGON
SUBRECIPIENT GRANT AGREEMENT 20-017

Project Name: ***ESG Title IV-B***
Project Number: ***53700***

This Agreement is between **Clackamas County**, Oregon, acting by and through its **Health, Housing and Human Services Department, Community Development Division** ("COUNTY") and **Northwest Housing Alternatives, Inc.** ("SUBRECIPIENT"), an Oregon Nonprofit Organization.

Clackamas County Data	
Grant Accountant: ***Larry Crumbaker***	Program Manager: ***Mark Sirois***
Clackamas County – Finance 2051 Kaen Road Oregon City, OR 97045 Phone 503-742-5429 larrycru@co.clackamas.or.us	Clackamas County – Community Development 2051 Kaen Road, Suite 245 Oregon City, OR 97045 Phone 503-650-5664 marksir@co.clackamas.or.us
Subrecipient Data	
Finance/Fiscal Representative: ***Vickie Howard***	Program Representative: ***Angela Mullins***
Northwest Housing Alternatives 2316 SE Willard Street Milwaukie OR 97222 503-654-1007 ext. 121 howard@nwhousing.org	Northwest Housing Alternatives 2316 SE Willard Street Milwaukie OR 97222 503-654-1007 x 103 Office mullins@nwhousing.org
DUNS: 180757437	

RECITALS

1. This Agreement is entered into between COUNTY and SUBRECIPIENT to provide a basis for a cooperative working relationship for the purpose of implementing the Emergency Solutions Grant program ("ESG") contained in Subpart B of Title IV of the Stewart B. McKinney Homeless Assistance Act, and regulations adopted under this Act at 24 CFR Part 576, dated October 26, 2011, as amended, and Public Law 100-77 as amended. The ESG program is designed to: improve existing homeless shelters; provide funds to operate emergency shelters; provide essential social services to homeless individuals; and, provide homeless prevention and rapid re-housing assistance.
2. COUNTY has been awarded ESG funds from the United States Department of Housing and Urban Development ("HUD") authorized by Subpart B of Title IV of the McKinney-Vento Homeless Assistance Act 42 U.S.C. 11371-11378.
3. Funds provided by COUNTY shall be used for eligible operating and maintenance expenditures for the **Annie Ross House Shelter** in Milwaukie, OR.
4. In response to a Congressional directive, HUD has required all recipients of Stewart B. McKinney Homeless Assistance Act funds to implement a Homeless Management Information System ("HMIS"). HMIS is a community–wide software solution that is designed to collect client-level information on the characteristics and service needs of youth experiencing homelessness.

NOW THEREFORE, according to the terms of this Subrecipient Grant Agreement (this "Agreement") the 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 **July 1, 2019** and not later than **June 30, 2020**, 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 Statement of Program Objectives. SUBRECIPIENT agrees to carry out 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, including Subpart B of Title IV of the McKinney-Vento Homeless Assistance Act 42 U.S.C. 11371-11378. Furthermore, SUBRECIPIENT shall comply with the requirements of the ESG award number E19-UC-41-0001 (Federal award date: 7/15/19) that is the source of the grant funding, in addition to compliance with requirements of Title IV of the *Code of Federal Regulations* (CFR), Part 24, Sub-Part 576. A copy of that grant award has been provided to SUBRECIPIENT by COUNTY, which is attached to and made a part of this Agreement by this reference. SUBRECIPIENT shall further comply with any requirements required by HUD, together with any and all terms, conditions, and other obligations as may be required by the applicable local, State or Federal agencies providing funding for performance under this Agreement, whether or not specifically referenced herein. SUBRECIPIENT 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 to comply with applicable State or Federal funding requirements.

4. **Grant Funds**. COUNTY's funding for this Agreement is the Emergency Solutions Grant (Catalogue of Federal Domestic Assistance [CFDA] #: 14.231) issued to COUNTY by the U.S. Department of Housing and Urban Development, Office of Community Planning and Development (Federal Award Identification # E19-UC-41-0001). The maximum, not to exceed, grant amount COUNTY will pay is **$40,000.00.** This is a cost reimbursement grant and disbursements will be made in accordance with the schedule and requirements contained in Exhibit D: Required Financial Reporting and Reimbursement Request. Failure to comply with the terms of this Agreement may result in withholding of payment or termination of the Agreement.

5. **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 executed before SUBRECIPIENT performs work subject to the amendment.

6. **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; or,

c. Written notice provided by COUNTY that HUD has determined that ESG funds are no longer available for the purposes outlined in this Agreement.

Upon completion of improvements or upon termination of this Agreement, any unexpended balances of ESG funds shall remain with COUNTY.

7. **Funds Available and Authorized.** COUNTY certifies that funds sufficient to pay for this Agreement have been obligated to COUNTY. 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 sole administrative discretion, to continue to make payments under this Agreement.

8. **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 Section 7.

9. **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 assistance to the homeless.

10. **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 2 CFR Part 200, Subpart D—*Post Federal Award Requirements*, and agrees to adhere to the accounting principles and procedures required therein, 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) **Personnel.** If SUBERECIPIENT becomes aware of any likely or actual changes to key systems, or grant-funded program personnel or administration staffing changes, SUBRECIPIENT shall notify COUNTY in writing within 30 days of becoming aware of the likely or actual changes and a statement of whether or not SUBRECIPIENT will be able to maintain compliance at all times with all requirements of this Agreement.

d) **Cost Principles.** SUBRECIPIENT shall administer the award in conformity with 2 CFR 200, Subpart E. These cost principles must be applied for all costs incurred whether charged on a direct or indirect basis. Costs disallowed by the Federal government shall be the liability of SUBRECIPIENT. Additionally, SUBRECIPIENT agrees to use funds provided only for eligible activities as described in 24 CFR 576 Subpart B.

e) **Period of Availability.** SUBRECIPIENT may charge to the award only allowable costs resulting from obligations incurred during the funding period.

f) **Budget.** SUBRECIPIENT use of funds may not exceed the amounts specified in the Exhibit B: Subrecipient Program Budget. SUBRECIPIENT may not transfer grant funds between budget lines without the prior written approval of COUNTY. At no time may budget modification change the scope of the original grant application or Agreement.

g) **Indirect Cost Recovery.** Indirect cost recovery is statutorily unavailable on this award.

h) **Research and Development.** SUBRECIPIENT certifies that this award is not for research and development purposes.

i) **Payment.** SUBRECIPIENT must submit a final request for payment no later than fifteen (15) days after the end date of this Agreement. Routine requests for reimbursement should be submitted as specified in Exhibit D: Required Financial Reporting and Reimbursement Request.

j) **Performance Reporting.** SUBRECIPIENT must submit Performance Reports as specified in Exhibit E.

k) **Evaluation.** SUBRECIPIENT agrees to participate with COUNTY in any evaluation project or performance report, as designed by COUNTY or HUD, and to make available all information required by any such evaluation process.

l) **Financial Reporting.** Methods and procedures for payment shall minimize the time elapsing between the transfer of funds and disbursement by COUNTY or SUBRECIPIENT, in accordance with Treasurer regulations at 31 CFR Part 205. Therefore, upon execution of this Agreement, SUBRECIPIENT will submit completed Exhibit D: Required Financial Reporting and Reimbursement Request on a monthly basis.

m) **Specific Conditions.** None.

n) **Grantor Recognition.** SUBRECIPIENT shall insure recognition of the role of COUNTY in providing services through this Agreement. All activities, facilities and items utilized pursuant to this Agreement shall be prominently labeled as to funding source. In addition, SUBRECIPIENT will include reference to the support provided herein in all publications made possible with funds available under this Agreement.

o) **Supplanting**. The funding made available under this Agreement shall not be utilized by SUBRECIPIENT to reduce substantially (i.e. supplant) the amount of local financial support for shelter and assistance activities below the level of such support prior to the availability of funds under this Agreement.

p) **Closeout**. COUNTY will closeout this award when COUNTY determines that all applicable administrative actions and all required work have been completed by SUBRECIPIENT, pursuant to 2 CFR 200.343—*Closeout*. SUBRECIPIENT must liquidate all obligations incurred under this award and must submit all financial (Exhibits D & G), performance, and other reports as required by the terms and conditions of the Federal award and/or COUNTY, no later than 90 calendar days after the end date of this agreement.

q) **Universal Identifier and Contract Status.** SUBRECIPIENT shall comply with 2 CFR 25.200-205 and apply for a unique universal identification number using the Data Universal Numbering System (DUNS) as required for receipt of funding. In addition, SUBRECIPIENT shall register and maintain an active registration in the Central Contractor Registration database, now located at https://www.sam.gov.

r) **Suspension and Debarment.** SUBRECIPIENT shall comply with 2 CFR 180.220 and 901. This common rule restricts sub-awards and contracts with certain parties that are debarred, suspended or otherwise excluded from or ineligible for participation in Federal assistance programs or activities. SUBRECIPIENT is responsible for further requiring the inclusion of a similar term or condition in any subsequent lower tier covered transactions. SUBRECIPIENT may access the Excluded Parties List System at https://www.sam.gov. The Excluded Parties List System 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 Orders 12549 and 12689. Awards that exceed the simplified acquisition threshold shall provide the required certification regarding their exclusion status and that of their principals prior to award.

s) **Lobbying.** SUBRECIPIENT certifies (Exhibit C: Lobbying) that no portion of the Federal grant funds will be used to engage in lobbying of the Federal Government or in litigation against the United States unless authorized under existing law and shall abide by 2 CFR 200.450 and the Byrd Anti-Lobbying Amendment 31 U. S. C. 1352. In addition, SUBRECIPIENT certifies that it is a nonprofit organization described in Section 501(c) (4) of the Code, but does not and will not engage in lobbying activities as defined in Section 3 of the Lobbying Disclosure Act.

t) **Audit**. SUBRECIPIENT shall comply with the audit requirements prescribed in the Single Audit Act Amendments and the new Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, located in 2 CFR 200.501. SUBRECIPIENT expenditures of $750,000 or more in Federal funds require an annual Single Audit. SUBRECIPIENT is required to hire an independent auditor qualified to perform a Single Audit. Subrecipients of Federal awards are required under the Uniform Guidance to submit their audits to the Federal Audit Clearinghouse (FAC) within 9 months from SUBRECIPIENT'S fiscal year end or 30 days after issuance of the reports, whichever is sooner. The website for submissions to the FAC is *https://harvester.census.gov/facweb/*. At the time of submission to the FAC, the SUBRECIPIENT will also submit a copy of the audit to COUNTY. If requested and if SUBRECIPIENT does not meet the threshold for the Single Audit requirement, SUBRECIPIENT shall submit to COUNTY a financial audit or independent review of financial statements within 9 months from SUBRECIPIENT'S fiscal year end or 30 days after issuance of the reports, whichever is sooner.

u) **Monitoring.** SUBRECIPIENT agrees to allow COUNTY access to conduct site visits and inspections of financial records for the purpose of monitoring in accordance with 2 CFR 200.331. COUNTY, the Federal government, and their duly authorized representatives shall have access to such financial 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 and transcripts. Monitoring may be performed onsite or offsite, at COUNTY's discretion. Depending on the outcomes of the financial monitoring processes, this Agreement shall either a) continue pursuant to the original terms, b) continue pursuant to the original terms and any additional conditions or remediation deemed appropriate by COUNTY, or c) be de-obligated and terminated.

COUNTY will monitor the performance of SUBRECIPIENT against goals and performance standards required herein. Substandard performance as determined by COUNTY will constitute non-compliance with this Agreement. If action to correct such substandard performance is not taken by SUBRECIPIENT within ten (10) days after being notified by COUNTY, Agreement termination and all funding will end. SUBRECIPIENT must return any unused funds promptly.

v) **Records to be Maintained.** SUBRECIPIENT shall maintain all records required by the Federal regulations specified in 24 CFR Part 576.500 that are pertinent to the activities to be funded under this Agreement. Such records shall include but are not limited to:

1. Client Eligibility Determinations and documentation;

2. Rental Assistance Agreements;
3. Service and assistance provided;
4. Records required to document the acquisition, improvement, use, or disposition of real property acquired or improved with ESG funds; Financial records as required by 24 CFR Part 576 Subpart F.
5. Client Data. SUBRECIPIENT shall maintain client data demonstrating client eligibility for services provided. Such data shall include, but is not limited to: client name, address, income level or other basis for determining eligibility, and description of service provided. Such information shall be made available to COUNTY monitors or their designees for review upon request.
6. Disclosure. SUBRECIPIENT understands that client information collected under this Agreement is private and the use or disclosure of such information, when not directly connected with the administration of COUNTY's or SUBRECIPIENT's responsibilities with respect to services provided under this Agreement, is prohibited unless consent is obtained from such person receiving service and, in the case of a minor, that of a responsible parent/guardian.
7. Property Records. SUBRECIPIENT shall maintain real property inventory records which clearly identify properties purchased, improved, or sold. Properties retained shall continue to meet eligibility criteria and shall conform with the "changes in use" restrictions specified in 24 CFR Parts 570.503(b)(8), as applicable.

w) **Record Retention**. SUBRECIPIENT shall retain all records pertinent to expenditures incurred under this Agreement for a period of five (5) years after the termination of all activities funded under this Agreement. Records for non-expendable property acquired with funds under this Agreement shall be retained for five (5) years after final disposition of such property. Records for any displaced person must be kept for five (5) years after he/she has received final payment. Notwithstanding the above, if there is litigation, claims, audits, negotiations, or other actions that involve any of the records cited and that have started before the expiration of the five-year period, then such records must be retained until completion of the actions and resolution of all issues, or the expiration of the five-year period, whichever occurs later.

x) **Fiduciary Duty.** SUBRECIPIENT acknowledges that it has read the award conditions and certifications for ESG, that it understands and accepts those conditions and certifications, and that it agrees to comply with all the obligations, and be bound by any limitations applicable to COUNTY, as grantee, under those grant documents.

y) **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 grant 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 or to terminate this relationship including the original Agreement and all associated amendments.

z) **Program Income**. SUBRECIPIENT shall report monthly all program income as defined at 2 CFR 200.80 generated by activities carried out with ESG funds made available under this Agreement. By way of further limitations, SUBRECIPIENT may use such income during the Agreement period for activities permitted under this Agreement and shall reduce request for additional funds by the amount of any such program income balances on hand. All unused program income shall be returned to COUNTY at the end of the Agreement period.

11. 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, "Equal Employment Opportunity" 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 2 CFR Part 200 as applicable to SUBRECIPIENT. See Exhibit A for additional requirements.

b) **Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251 et seq.).** SUBRECIPIENT agrees that if this Agreement is in excess of $150,000, the recipient agrees to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. 7401 et seq., and the Federal Water Pollution Control Act, as amended 33 U.S.C. 1251 et seq. Violations shall be reported to the awarding Federal Department and the appropriate Regional Office of the Environmental Protection Agency.

c) **Lead-Based Paint**. SUBRECIPIENT agrees to comply with the Lead-Based Paint Poisoning Prevention Act and implementing regulations at 24 CFR Part 35.

d) **Drug-Free Workplace Act of 1988**. SUBRECIPIENT agrees to comply with the requirements of 24 CFR Part 24 concerning the Drug-Free Workplace Act of 1988 by administering in good faith a policy designed to ensure that its facilities are free from the illegal use, possession, or distribution of drugs or alcohol by its beneficiaries.

e) **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.

f) **Conflict Resolution.** If potential, actual or perceived conflicts are discovered among federal, state and local statutes, regulations, administrative rules, executive orders, ordinances or other laws applicable to the Services under the Agreement, SUBRECIPIENT may in writing request COUNTY to resolve the conflict. SUBRECIPIENT shall specify if the conflict(s) create a problem for the design or other Services required under the Agreement. COUNTY shall undertake reasonable efforts to resolve the issue but is not required to deliver any specific answer or product. SUBRECIPIENT shall remain obligated to independently comply with all applicable laws and no action by COUNTY shall be deemed a guarantee, waiver, or indemnity for non-compliance with any law.

g) **Disclosure of Information.** Any confidential or personally identifiable information (2 CFR 200.82) acquired by SUBRECIPIENT during the execution of the project should not be disclosed during or upon termination or expiration of this Agreement for any reason or purpose without the prior written consent of COUNTY. SUBRECIPIENT further agrees to take reasonable measures to safeguard such information (2 CFR 200.303) and to follow all applicable federal, state and local regulations regarding privacy and obligations of confidentiality.

h) **Mileage reimbursement.** If mileage reimbursement is authorized in SUBRECIPIENT budget or by the written approval of COUNTY, mileage must be paid at the rate established by SUBRECIPIENT'S written policies covering all organizational mileage reimbursement or at the IRS mileage rate at the time of travel, whichever is lowest.

12. Federal and State Procurement Standards

a) All procurement transactions, whether negotiated or competitively bid and without regard to dollar value, shall be conducted in a manner so as to provide maximum open and free competition. All sole-source procurements must receive prior written approval from COUNTY in addition to any other approvals required by law applicable to SUBRECIPIENT. Justification for sole-source procurement

should include a description of the project and what is being contracted for, an explanation of why it is necessary to contract noncompetitively, time constraints and any other pertinent information. Interagency agreements between units of government are excluded from this provision. SUBRECIPIENT shall comply with the procurement standards applying to subrecipients under this Federal award contained in 2 CFR 200.318-326.

b) COUNTY's performance under the Agreement is conditioned upon SUBRECIPIENT's compliance with, and SUBRECIPIENT shall comply with, the obligations applicable to public contracts under the Oregon Public Contracting Code and applicable Local Contract Review Board rules, which are incorporated by reference herein.

c) SUBRECIPIENT must maintain written standards of conduct covering conflicts of interest and governing the performance of its employees engaged in the selection, award and administration of contracts. If SUBRECIPIENT has a parent, affiliate, or subsidiary organization that is not a state, local government, or Indian tribe, SUBRECIPIENT must also maintain written standards of conduct covering organizational conflicts of interest. SUBRECIPIENT shall be alert to organizational conflicts of interest or non-competitive practices among contractors that may restrict or eliminate competition or otherwise restrain trade. Contractors that develop or draft specifications, requirements, statements of work, and/or Requests for Proposals ("RFP") for a proposed procurement must be excluded by SUBRECIPIENT from bidding or submitting a proposal to compete for the award of such procurement. Any request for exemption must be submitted in writing to COUNTY.

d) SUBRECIPIENT agrees that, to the extent they use contractors or subcontractors, such recipients shall use small, minority, women-owned or disadvantaged business concerns and contractors or subcontractors to the extent practicable.

13. **General Agreement Provisions**.

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 indemnify and hold COUNTY and its commissioners, officers, employees, and agents 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 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 the COUNTY evidence of Professional Liability Insurance in the amount of not less than $1,000,000 combined single limit per occurrence/$2,000,000 general annual aggregate for malpractice or errors and omissions coverage 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) **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, commissioners, officers, and employees" as an additional insured.

5) **Notice of Cancellation.** There shall be no cancellation, material change, exhaustion of aggregate limits or intent not to renew insurance coverage without 60 days written notice to COUNTY. Any failure to comply with this provision will not affect the insurance coverage provided to COUNTY. The 60 days-notice of cancellation provision shall be physically endorsed on to the policy.

6) **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.

7) **Certificates of Insurance.** As evidence of the insurance coverage required by this Agreement, SUBRECIPIENT shall furnish a Certificate of Insurance to COUNTY. COUNTY and its officers must be named as an additional insured on the Certificate of Insurance. No Agreement shall be in effect until the required certificates have been received, approved, and accepted by COUNTY. The certificate will specify that all insurance-related provisions within the Agreement have been complied with. A renewal certificate will be sent to COUNTY 10 days prior to coverage expiration.

8) **Primary Coverage Clarification**. SUBRECIPIENT coverage will be primary in the event of a loss.

9) **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.

d) **Subagreement**. SUBRECIPIENT shall not enter into any subagreements with any agency or individual in the performance of this Agreement.

e) **Binding Effect.** This Agreement shall be binding on all parties hereto, their heirs, administrators, executors, successors and assigns.

f) **Integration**. This Agreement contains the entire Agreement between COUNTY and SUBRECIPIENT and supersedes all prior written or oral discussions or Agreements.

14. Other Federal Requirements

a) The requirements in 24 CFR part 5, subpart A are applicable, including the nondiscrimination and equal opportunity requirements at 24 CFR 5.105(a). Section 3 of the Housing and Urban Development Act of 1968, 12 U.S.C. 1701u, and implementing regulations at 24 CFR part 135 apply, except that homeless individuals have priority over other Section 3 residents in accordance with § 576.405(c).

b) **Hatch Act**. SUBRECIPIENT agrees that no funds provided, nor personnel employed under this Agreement, shall be in any way or to any extent engaged in the conduct of political activities in violation of Chapter 15 of the Title V United States Code.

c) **Affirmative outreach**. SUBRECIPIENT must make known that use of the facilities, assistance, and services are available to all on a nondiscriminatory basis. If it is unlikely that the procedures that the recipient or subrecipient intends to use to make known the availability of the facilities, assistance, and services will to reach persons of any particular race, color, religion, sex, age, national origin, familial status, or disability who may qualify for those facilities and services, the recipient or subrecipient must establish additional procedures that ensure that those persons are made aware of the facilities, assistance, and services. SUBRECIPIENT must take appropriate steps to ensure effective communication with persons with disabilities including, but not limited to, adopting procedures that will make available to interested persons information concerning the location of assistance, services, and facilities that are accessible to persons with disabilities. Consistent with Title VI and Executive Order 13166, SUBRECIPIENT is also required to take reasonable steps to ensure meaningful access to programs and activities for limited English proficiency ("LEP") persons.

d) **Uniform Administrative Requirements**. The requirements of 2 CFR part 200 apply to SUBRECIPIENT; program income is to be used as the nonfederal share under 2 CFR 200.307(e). These regulations include allowable costs and non-Federal audit requirements.

e) Religious Organization. SUBRECIPIENT agrees that funds provided under this Agreement will not be utilized for religious activities, to promote religious interest, or for the benefit of a religious organization in accordance with the Federal regulations specified in 24 CFR 576.406.

f) **Environmental review responsibilities**.

a. Activities under this part are subject to environmental review by HUD under 24 CFR Part 50. SUBRECIPIENT shall supply all available, relevant information necessary for COUNTY to perform for each property any environmental review required by 24 CFR part 50. At the instruction of COUNTY SUBRECIPIENT may be required to carry out mitigating measures required by COUNTY or select alternate eligible property. COUNTY may eliminate from consideration any application that would require an Environmental Impact Statement ("EIS").

b. SUBRECIPIENT, or any contractor of SUBRECIPIENT, may not acquire, rehabilitate, convert, lease, repair, dispose of, demolish, or construct property for a project under this part, or commit or expend HUD or local funds for eligible activities under this part, until COUNTY has performed an environmental review under 24 CFR part 50 and SUBRECIPIENT has received COUNTY approval of the property.

g) **Davis-Bacon Act**. The provisions of the Davis-Bacon Act (40 U.S.C. 276a to 276a–5) do not apply to the ESG program.

h) **Procurement of Recovered Materials**. SUBRECIPIENT and its contractors must comply with Section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act. The requirements of Section 6002 include procuring only items designated in guidelines of the Environmental Protection Agency ("EPA") at 40 CFR part 247 that contain the highest percentage of recovered materials practicable, consistent with maintaining a satisfactory level of competition, where the purchase price of the item exceeds $10,000 or the value of the quantity

acquired by the preceding fiscal year exceeded $10,000; procuring solid waste management services in a manner that maximizes energy and resource recovery; and establishing an affirmative procurement program for procurement of recovered materials identified in the EPA guidelines.

i) **Displacement, Relocation, and Acquisition**. Consistent with the other goals and objectives of ESG, SUBRECIPIENT must assure that they have taken all reasonable steps to minimize the displacement of persons (families, individuals, businesses, nonprofit organizations, and farms) as a result of a project assisted under ESG.

j) **Temporary relocation not permitted**. No tenant-occupant of housing (a dwelling unit) that is converted into an emergency shelter may be required to relocate temporarily for a project assisted with ESG funds, or be required to move to another unit in the same building/complex. When a tenant moves for a project assisted with ESG funds under conditions that trigger the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 ("URA"), 42 U.S.C. 4601–4655, as described in paragraph (c) of this section, the tenant should be treated as permanently displaced and offered relocation assistance and payments consistent with that paragraph.

k) **Non-displacement.** SUBRECIPIENT agrees to minimize displacement and comply with (a) the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, as amended and implementing regulations at 49 CFR Part 24 and (b) the requirements of 24 CFR 576.408 governing the ESG program. SUBRECIPIENT shall provide relocation assistance to persons (families, individuals, businesses, nonprofit organizations, and farms) that are displaced as a direct result of acquisition, rehabilitation, demolition or conversion for an ESG-assisted project. SUBRECIPIENT also agrees to comply with applicable COUNTY ordinances, resolutions, and policies concerning the displacement of persons from their residences. Any activity which may result in a displaced person (defined in paragraph l. of this section) must be reported to COUNTY prior to the commencement of the activity. COUNTY shall determine the relocation assistance as provided in 24 CFR 576.408(c). All such assistance shall be subtracted from the ESG funds provided to SUBRECIPIENT.

l) **Displaced Person**. For purposes of paragraph k. of this section, the term "displaced person" means any person (family, individual, business, nonprofit organization, or farm, including any corporation, partnership, or association) that moves from real property, or moves personal property from real property, permanently, as a direct result of acquisition, rehabilitation, or demolition for a project assisted under the ESG program. This includes any permanent, involuntary move for an assisted project, including any permanent move from the real property.

m) **Real property acquisition requirements**. The acquisition of real property, whether funded privately or publicly, for a project assisted with ESG funds is subject to the URA and Federal government wide regulations at 49 CFR Part 24, subpart B.

n) **Appeals**. A person who disagrees with COUNTY'S (or SUBRECIPIENT'S, if applicable) determination concerning whether the person qualifies as a displaced person, or the amount of relocation assistance for which the person may be eligible, may file a written appeal of that determination with the recipient under 49 CFR 24.10. A low-income person who disagrees with the recipient's determination may submit a written request for review of that determination by the appropriate HUD field office.

15. Civil Rights

a) **Compliance**. SUBRECIPIENT agrees to comply with Title VI of the Civil Rights Act of 1964 as amended, Title VIII of the Civil Rights Act of 1968 as amended, Section 104(b) and Section 109 of Title I of Housing and Community Development Act of 1974 as amended, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, Executive Order 11063, and with Executive Order 11246 as amended by Executive Order 11375 and 12086.

b) **Nondiscrimination**. SUBRECIPIENT will not discriminate against any employee or applicant for employment because of race, color, creed, religion, ancestry, nation origin, sex, disability, or other handicap, age, marital/familial status, or status with regard to public assistance. SUBRECIPIENT will take affirmative action to insure that all employment practices are free from such discrimination. Such employment practices include but are not limited to the following: hiring, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff, termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship. SUBRECIPIENT agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by COUNTY setting forth the provisions of this nondiscrimination clause.

c) **Section 504**. SUBRECIPIENT agrees to comply with any Federal regulations issued pursuant to compliance with Section 504 of the Rehabilitation Act of 1974, which prohibits discrimination against the handicapped in any Federally-assisted program. COUNTY shall provide SUBRECIPIENT with any guidelines necessary for compliance with that portion of the regulations in force during the term of this Agreement.

16. Affirmative Action

a) **Plan**. SUBRECIPIENT agrees that it shall be committed to carry out pursuant to COUNTY's specifications an Affirmative Action Program in keeping with the principles as provided in President's Executive Order 11246 of September 24, 1965.

b) **Women and Minority Business Enterprises**. SUBRECIPIENT will use its best efforts to afford minority- and women-owned business enterprises the maximum practicable opportunity to participate in the performance of this Agreement. As used in this Agreement, the term "minority and female business enterprise" means a business at least fifty-one (51) percent owned and controlled by minority group members or women. For the purpose of this definition, "minority group members" are Afro-Americans, Spanish-speaking, Spanish surnamed or Spanish-heritage Americans, Asian-Americans, and American Indians. SUBRECIPIENT may rely on written representation by businesses regarding their status as minority and female business enterprises in lieu of an independent investigation.

c) **Access to Records**. SUBRECIPIENT shall furnish and cause each of its own subrecipients or subcontractors to furnish all information and reports required hereunder and will permit access to its books, records and accounts by COUNTY, HUD or its agent, or other authorized Federal officials for purposes of investigation to ascertain compliance with the rules, regulations, and provisions stated herein.

d) **Notifications**. SUBRECIPIENT will send to each labor union or representative of workers with which it has a collective bargaining agreement or other Agreement or understandings, a notice, provided by COUNTY, advising the labor union or worker's representative of SUBRECIPIENT's commitments hereunder, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

e) **EEO/AA Statement**. SUBRECIPIENT will, in all solicitations or advertisements for employees placed by or on behalf of SUBRECIPIENT, state that it is an Equal Opportunity or Affirmative Action employer.

f) **Subcontracting Provisions**. SUBRECIPIENT will include the provisions of Paragraph 23, Civil Rights, and 24, Affirmative Action, in every subcontract or purchase orders, specifically or by reference, so that such provisions will be binding upon each of its subrecipients or subcontractors.

17. Employment Restrictions

a) **Prohibited Activity**. SUBRECIPIENT is prohibited from using funds provided herein or personnel employed in the administration of the program for: political activities, sectarian or religious activities, lobbying, political patronage, and nepotism activities.

b) **Labor Standards**. SUBRECIPIENT agrees to comply with the requirements of the Secretary of Labor in accordance with Davis-Bacon Act as amended, the provisions of Agreement: Work Hours and Safety Standards Act, the Copeland "Anti-Kickback" Act and all other applicable Federal, state and local laws and regulations pertaining to labor standards insofar as those acts apply to the performance of this Agreement. SUBRECIPIENT shall maintain documentation which demonstrates compliance with hour and wage requirements of this part. Such documentation shall be made available to COUNTY for review upon request. SUBRECIPIENT agrees that, except with respect to the rehabilitation or construction of residential property containing less than eight (8) units, all Agreements engaged under Agreements in excess of $2,000.00 for construction, renovation or repair work financed in whole or in part with assistance provided under this Agreement, shall comply with Federal requirements adopted by COUNTY pertaining to such Agreements and with the applicable requirements of the regulations of the Department of Labor, under 29 CFR Parts 1, 3, 5 and 7 governing the payment of wages and ratio of apprentices and trainees to journey-workers; provide, that if wage rates higher than those required under the regulations are imposed by state or local laws, nothing hereunder is intended to relieve SUBRECIPIENT of its obligation, if any, to require payment of the higher wage. SUBRECIPIENT will cause or require to be inserted in full, in all Agreements subject to such regulations, provisions meeting the requirements of this paragraph.

c) Job Training and Employment for Low-income Residents -Section 3

i. **Compliance**. Compliance with the provisions of Section 3, the regulations set forth in 24 CFR 135, and all applicable rules and orders issued hereunder prior to the execution of this Agreement, shall be a condition of the Federal financial assistance provided under this Agreement and binding upon COUNTY, SUBRECIPIENT, and any of SUBRECIPIENT's subrecipients and subcontractors. Failure to fulfill these requirements shall subject the COUNTY, SUBRECIPIENT, and any of SUBRECIPIENT's subrecipients and subcontractors, their successors and assigns, to those sanctions specified by the Agreement through which Federal assistance is provided. SUBRECIPIENT certifies and agrees that no agreements or disability exist which would prevent compliance with these requirements.

ii. SUBRECIPIENT further agrees to comply with these "Section 3" requirements and to include the following language in all subcontracts executed under this Agreement:

"The work to be performed under this Agreement is a project assisted under a program providing direct Federal financial assistance from HUD and is subject to the requirements of Section 3 of the Housing and Community Development Act of 1968, as amended, 12 U.S.C. 1701. Section 3 requires that to the greatest extent feasible opportunities for training and employment be given to low-and very low-income residents of the project area and Agreements for work in connection with the project be awarded to business concerns that provide economic opportunities for low- and very low-income persons residing in the metropolitan area in which the project is located."

iii. SUBRECIPIENT further agrees to ensure that opportunities for training and employment arising in connection with a housing rehabilitation, housing construction, or other public construction project are given to low- and very low-income persons residing with in the metropolitan area in which the ESG funded project is located; where feasible, priority should be given to low- and very low-income persons within the service area of the project or neighborhood in which the project is located, and to low- and very low-income participants in other HUD programs; and award Agreements for work undertaken in connection to housing rehabilitation, housing construction, or other public construction project are given to business concerns that provide economic opportunities for low- and very low-income persons residing within the metropolitan

area in which ESG-funded project is located; where feasible, priority should be given to business concerns which provide economic opportunities to low- and very low-income residents within the service area or neighborhood in which the project is located, and to low- and very low-income participants in other HUD programs.

iv. SUBRECIPIENT certifies and agrees that no agreements or legal incapacity exists which would prevent compliance with these requirements.

v. **Notifications**. SUBRECIPIENT agrees to send to each labor organization or representative of worker with which it has a collective bargaining agreement or other Agreement or understanding, if any, a notice advising said labor organization or worker's representative of its commitments under this Section 3 clause and shall post copies of the notice in conspicuous places available to employees and applicants for employment or training.

vi. **Subcontracts**. SUBRECIPIENT will include this Section 3 clause in every subcontract and will take appropriate action pursuant to the subcontract upon a finding that the subcontract is in violation of regulations issued by the grantor agency. SUBRECIPIENT will not subcontract with any entity where it has notice or knowledge that the latter has been found in violation of regulations under 24 CFR 135 and will not let any subcontract unless the entity has first provided it with a preliminary statement of ability to comply with the requirements of these regulations.

18. **Assignment.** This Agreement may not be assigned in whole or in part without the prior express written approval of COUNTY.

19. **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.

20. **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.

21. **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 without giving effect to the conflict of law provisions thereof. 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.

22. **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.

23. **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.

24. **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.

(Signature Page Follows)

SIGNATURE PAGE TO SUBRECIPIENT GRANT AGREEMENT

AGREED as of the Effective Date.

CLACKAMAS COUNTY

Commissioner: Jim Bernard, Chair
Commissioner: Sonya Fischer
Commissioner: Ken Humbertson
Commissioner: Paul Savas
Commissioner: Martha Schrader

Signing on Behalf of the Board,

By: _____
Richard Swift, Director
Health, Housing and Human Services

By: _____
Recording Secretary

Dated: _____

Approved to Form

By: _____
County Counsel

Dated: _____

NORTHWEST HOUSING ALTERNATIVES

By: Trell Anderson
Trell Anderson, Executive Director

Dated: 8/21/19

- Exhibit A: SUBRECIPIENT Statement of Program Objectives & Requirements
- Exhibit A.1 SUBRECIPIENT Scope of Work
- Exhibit B: SUBRECIPIENT Program Budget
- Exhibit C: Lobbying Certificate
- Exhibit D: Required Financial Reporting and Reimbursement Request
- Exhibit E: Subrecipient Performance Reporting
- Exhibit F: Required Certifications
- Exhibit G: Final Financial Report

- Attachment A: ESG Policies

Health, Housing & Human Services
CLACKAMAS COUNTY

COPY

Richard Swift
Director

September 5, 2019

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of a Sub-recipient Agreement with Northwest Housing Alternatives and the Community Development Division for
ESG Funding for the Homebase Rapid Re-Housing services

Purpose/ Outcome	The Emergency Solutions Grant (ESG) program is designed to: improve existing homeless shelters; provide funds to operate emergency shelters; provide essential social services to homeless individuals and; provide homeless prevention and rapid re-housing assistance.
Dollar Amount and Fiscal Impact	Emergency Solutions Grant (ESG) funds of $20,678 as a grant. No County General Funds are included in this Agreement
Funding Source	U.S. Department of Housing and Urban Development ESG funds
Duration	July 1, 2019 to June 30, 2020
Previous Board Action/ Review	May 2, 2019 approval of the 2019 One-Year Action Plan which included a funding recommendation of $20,678 of ESG funds to be available for NHA.
Strategic Plan Alignment	Increase self-sufficiency for our clients. Ensure safe, healthy and secure communities.
County Review	The Sub-recipient agreement was reviewed and approved by County Counsel on August 13, 2019.
Contact Person	Mark Sirois, Project Coordinator - Community Development: 503-655-8359
Contract No.	H3S 9447

BACKGROUND: The Community Development Division of the Health, Housing and Human Services Department requests the approval of a Sub-recipient Agreement for eligible rapid re-housing case management expenditures for Northwest Housing Alternatives (NHA) Homebase Rapid Re-Housing services in Clackamas County, OR. In December of 2016 NHA applied for Emergency Solutions Grant (ESG) funding to provide homeless rapid re-housing services in Clackamas County. NHA was awarded 3 years of funding for FY 2017, FY 2018 and FY 2019. Each year a new sub-recipient agreement is signed.

PROJECT OVERVIEW: NHA will provide Rapid Re-housing services including: Safety planning, Advocacy and assistance navigating systems, Case management, Crisis intervention, Information and Referral, Support groups and Counseling. It is expected that the limited funding under this ESG contract will assist approximately 5 homeless families to secure housing during the program year.

RECOMMENDATION: We recommend the approval of this Sub-recipient Agreement and that Richard Swift H3S Director be authorized to sign on behalf of the Board of County Commissioners.

Respectfully submitted,

Rodney A. Cook, H3S Deputy Director/For

Richard Swift, Director
Health, Housing Human Services

CLACKAMAS COUNTY, OREGON SUBRECIPIENT GRANT AGREEMENT 20-019	
Project Name: ***ESG Title IV-B*** Project Number: **53701**	
This Agreement is between **Clackamas County**, Oregon, acting by and through its **Health, Housing and Human Services Department, Community Development Division** ("COUNTY") and **Northwest Housing Alternatives, Inc.,** ("SUBRECIPIENT"), an Oregon Nonprofit Organization.	
Clackamas County Data	
Grant Accountant: ***Larry Crumbaker***	Program Manager: ***Mark Sirois***
Clackamas County – Finance 2051 Kaen Road Oregon City, OR 97045 Phone 503-742-5429 larrycru@co.clackamas.or.us	Clackamas County – Community Development 2051 Kaen Road, Suite 245 Oregon City, OR 97045 Phone 503-650-5664 marksir@co.clackamas.or.us
Subrecipient Data	
Finance/Fiscal Representative: ***Vickie Howard***	Program Representative: ***Angela Trimble***
Northwest Housing Alternatives 2316 SE Willard Street Milwaukie OR 97222 503-654-1007 ext. 121 howard@nwhousing.org	Northwest Housing Alternatives 2316 SE Willard Street Milwaukie OR 97222 503-654-1007 x 103 Office trimble@nwhousing.org
DUNS: 180757437	

RECITALS

1. This Agreement is entered into between COUNTY and SUBRECIPIENT to provide a basis for a cooperative working relationship for the purpose of implementing the Emergency Solutions Grant program ("ESG") contained in Subpart B of Title IV of the Stewart B. McKinney Homeless Assistance Act, and regulations adopted under this Act at 24 CFR Part 576, dated October 26, 2011, as amended, and Public Law 100-77 as amended. The ESG program is designed to: improve existing homeless shelters; provide funds to operate emergency shelters; provide essential social services to homeless individuals; and, provide homeless prevention and rapid re-housing assistance.
2. COUNTY has been awarded ESG funds from the United States Department of Housing and Urban Development ("HUD") authorized by Subpart B of Title IV of the McKinney-Vento Homeless Assistance Act 42 U.S.C. 11371-11378.
3. Funds provided by COUNTY shall be used for a **RAPID RE-HOUSING PROGRAM** for eligible participants throughout Clackamas County, OR.
4. In response to a Congressional directive, HUD has required all recipients of Stewart B. McKinney Homeless Assistance Act funds to implement a Homeless Management Information System ("HMIS"). HMIS is a community–wide software solution that is designed to collect client-level information on the characteristics and service needs of youth experiencing homelessness.

NOW THEREFORE, according to the terms of this Subrecipient Grant Agreement (this "Agreement") the 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 **July 1, 2019** and not later than **June 30, 2020**, 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 Statement of Program Objectives. SUBRECIPIENT agrees to carry out 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, including Subpart B of Title IV of the McKinney-Vento Homeless Assistance Act 42 U.S.C. 11371-11378. Furthermore, SUBRECIPIENT shall comply with the requirements of the ESG award number E19-UC-41-0001 (Federal award date: 7/15/19) that is the source of the grant funding, in addition to compliance with requirements of Title IV of the *Code of Federal Regulations* (CFR), Part 24, Sub-Part 576. A copy of that grant award has been provided to SUBRECIPIENT by COUNTY, which is attached to and made a part of this Agreement by this reference. SUBRECIPIENT shall further comply with any requirements required by HUD, together with any and all terms, conditions, and other obligations as may be required by the applicable local, State or Federal agencies providing funding for performance under this Agreement, whether or not specifically referenced herein. SUBRECIPIENT 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 to comply with applicable State or Federal funding requirements.

4. **Grant Funds**. COUNTY's funding for this Agreement is the Emergency Solutions Grant (Catalogue of Federal Domestic Assistance [CFDA] #: 14.231) issued to COUNTY by the U.S. Department of Housing and Urban Development, Office of Community Planning and Development (Federal Award Identification # E19-UC-41-0001). The maximum, not to exceed, grant amount COUNTY will pay is **$20,678.00.** This is a cost reimbursement grant and disbursements will be made in accordance with the schedule and requirements contained in Exhibit D: Required Financial Reporting and Reimbursement Request. Failure to comply with the terms of this Agreement may result in withholding of payment or termination of the Agreement.

5. **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 executed before SUBRECIPIENT performs work subject to the amendment.

6. **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; or,

c. Written notice provided by COUNTY that HUD has determined that ESG funds are no longer available for the purposes outlined in this Agreement.

Upon completion of improvements or upon termination of this Agreement, any unexpended balances of ESG funds shall remain with COUNTY.

7. **Funds Available and Authorized.** COUNTY certifies that funds sufficient to pay for this Agreement have been obligated to COUNTY. 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 sole administrative discretion, to continue to make payments under this Agreement.

8. **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 Section 7.

9. **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 assistance to the homeless.

10. **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 2 CFR Part 200, Subpart D—*Post Federal Award Requirements*, and agrees to adhere to the accounting principles and procedures required therein, 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) **Personnel.** If SUBERECIPIENT becomes aware of any likely or actual changes to key systems, or grant-funded program personnel or administration staffing changes, SUBRECIPIENT shall notify COUNTY in writing within 30 days of becoming aware of the likely or actual changes and a statement of whether or not SUBRECIPIENT will be able to maintain compliance at all times with all requirements of this Agreement.

d) **Cost Principles.** SUBRECIPIENT shall administer the award in conformity with 2 CFR 200, Subpart E. These cost principles must be applied for all costs incurred whether charged on a direct or indirect basis. Costs disallowed by the Federal government shall be the liability of SUBRECIPIENT. Additionally, SUBRECIPIENT agrees to use funds provided only for eligible activities as described in 24 CFR 576 Subpart B.

e) **Period of Availability.** SUBRECIPIENT may charge to the award only allowable costs resulting from obligations incurred during the funding period.

f) **Budget.** SUBRECIPIENT use of funds may not exceed the amounts specified in the Exhibit B: Subrecipient Program Budget. SUBRECIPIENT may not transfer grant funds between budget lines without the prior written approval of COUNTY. At no time may budget modification change the scope of the original grant application or Agreement.

g) **Indirect Cost Recovery.** Indirect cost recovery is statutorily unavailable on this award.

h) **Research and Development.** SUBRECIPIENT certifies that this award is not for research and development purposes.

i) **Payment.** SUBRECIPIENT must submit a final request for payment no later than fifteen (15) days after the end date of this Agreement. Routine requests for reimbursement should be submitted as specified in Exhibit D: Required Financial Reporting and Reimbursement Request.

j) **Performance Reporting.** SUBRECIPIENT must submit Performance Reports as specified in Exhibit E.

k) **Evaluation.** SUBRECIPIENT agrees to participate with COUNTY in any evaluation project or performance report, as designed by COUNTY or HUD, and to make available all information required by any such evaluation process.

l) **Financial Reporting.** Methods and procedures for payment shall minimize the time elapsing between the transfer of funds and disbursement by COUNTY or SUBRECIPIENT, in accordance with Treasurer regulations at 31 CFR Part 205. Therefore, upon execution of this Agreement, SUBRECIPIENT will submit completed Exhibit D: Required Financial Reporting and Reimbursement Request on a monthly basis.

m) **Specific Conditions.** None.

n) **Grantor Recognition.** SUBRECIPIENT shall insure recognition of the role of COUNTY in providing services through this Agreement. All activities, facilities and items utilized pursuant to this Agreement shall be prominently labeled as to funding source. In addition, SUBRECIPIENT will include reference to the support provided herein in all publications made possible with funds available under this Agreement.

o) **Supplanting**. The funding made available under this Agreement shall not be utilized by SUBRECIPIENT to reduce substantially (i.e. supplant) the amount of local financial support for shelter and assistance activities below the level of such support prior to the availability of funds under this Agreement.

p) **Closeout**. COUNTY will closeout this award when COUNTY determines that all applicable administrative actions and all required work have been completed by SUBRECIPIENT, pursuant to 2 CFR 200.343—*Closeout*. SUBRECIPIENT must liquidate all obligations incurred under this award and must submit all financial (Exhibits D & G), performance, and other reports as required by the terms and conditions of the Federal award and/or COUNTY, no later than 90 calendar days after the end date of this agreement.

q) **Universal Identifier and Contract Status.** SUBRECIPIENT shall comply with 2 CFR 25.200-205 and apply for a unique universal identification number using the Data Universal Numbering System (DUNS) as required for receipt of funding. In addition, SUBRECIPIENT shall register and maintain an active registration in the Central Contractor Registration database, now located at https://www.sam.gov.

r) **Suspension and Debarment.** SUBRECIPIENT shall comply with 2 CFR 180.220 and 901. This common rule restricts sub-awards and contracts with certain parties that are debarred, suspended or otherwise excluded from or ineligible for participation in Federal assistance programs or activities. SUBRECIPIENT is responsible for further requiring the inclusion of a similar term or condition in any subsequent lower tier covered transactions. SUBRECIPIENT may access the Excluded Parties List System at https://www.sam.gov. The Excluded Parties List System 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 Orders 12549 and 12689. Awards that exceed the simplified acquisition threshold shall provide the required certification regarding their exclusion status and that of their principals prior to award.

s) **Lobbying.** SUBRECIPIENT certifies (Exhibit C: Lobbying) that no portion of the Federal grant funds will be used to engage in lobbying of the Federal Government or in litigation against the United States unless authorized under existing law and shall abide by 2 CFR 200.450 and the Byrd Anti-Lobbying Amendment 31 U. S. C. 1352. In addition, SUBRECIPIENT certifies that it is a nonprofit organization described in Section 501(c) (4) of the Code, but does not and will not engage in lobbying activities as defined in Section 3 of the Lobbying Disclosure Act.

t) **Audit**. SUBRECIPIENT shall comply with the audit requirements prescribed in the Single Audit Act Amendments and the new Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, located in 2 CFR 200.501. SUBRECIPIENT expenditures of $750,000 or more in Federal funds require an annual Single Audit. SUBRECIPIENT is required to hire an independent auditor qualified to perform a Single Audit. Subrecipients of Federal awards are required under the Uniform Guidance to submit their audits to the Federal Audit Clearinghouse (FAC) within 9 months from SUBRECIPIENT'S fiscal year end or 30 days after issuance of the reports, whichever is sooner. The website for submissions to the FAC is *https://harvester.census.gov/facweb/*. At the time of submission to the FAC, the SUBRECIPIENT will also submit a copy of the audit to COUNTY. If requested and if SUBRECIPIENT does not meet the threshold for the Single Audit requirement, SUBRECIPIENT shall submit to COUNTY a financial audit or independent review of financial statements within 9 months from SUBRECIPIENT'S fiscal year end or 30 days after issuance of the reports, whichever is sooner.

u) **Monitoring.** SUBRECIPIENT agrees to allow COUNTY access to conduct site visits and inspections of financial records for the purpose of monitoring in accordance with 2 CFR 200.331. COUNTY, the Federal government, and their duly authorized representatives shall have access to such financial 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 and transcripts. Monitoring may be performed onsite or offsite, at COUNTY's discretion. Depending on the outcomes of the financial monitoring processes, this Agreement shall either a) continue pursuant to the original terms, b) continue pursuant to the original terms and any additional conditions or remediation deemed appropriate by COUNTY, or c) be de-obligated and terminated.

COUNTY will monitor the performance of SUBRECIPIENT against goals and performance standards required herein. Substandard performance as determined by COUNTY will constitute non-compliance with this Agreement. If action to correct such substandard performance is not taken by SUBRECIPIENT within ten (10) days after being notified by COUNTY, Agreement termination and all funding will end. SUBRECIPIENT must return any unused funds promptly.

v) **Records to be Maintained.** SUBRECIPIENT shall maintain all records required by the Federal regulations specified in 24 CFR Part 576.500 that are pertinent to the activities to be funded under this Agreement. Such records shall include but are not limited to:

1. Client Eligibility Determinations and documentation;

2. Rental Assistance Agreements;
3. Service and assistance provided;
4. Records required to document the acquisition, improvement, use, or disposition of real property acquired or improved with ESG funds; Financial records as required by 24 CFR Part 576 Subpart F.
5. Client Data. SUBRECIPIENT shall maintain client data demonstrating client eligibility for services provided. Such data shall include, but is not limited to: client name, address, income level or other basis for determining eligibility, and description of service provided. Such information shall be made available to COUNTY monitors or their designees for review upon request.
6. Disclosure. SUBRECIPIENT understands that client information collected under this Agreement is private and the use or disclosure of such information, when not directly connected with the administration of COUNTY's or SUBRECIPIENT's responsibilities with respect to services provided under this Agreement, is prohibited unless consent is obtained from such person receiving service and, in the case of a minor, that of a responsible parent/guardian.
7. Property Records. SUBRECIPIENT shall maintain real property inventory records which clearly identify properties purchased, improved, or sold. Properties retained shall continue to meet eligibility criteria and shall conform with the "changes in use" restrictions specified in 24 CFR Parts 570.503(b)(8), as applicable.

w) **Record Retention**. SUBRECIPIENT shall retain all records pertinent to expenditures incurred under this Agreement for a period of five (5) years after the termination of all activities funded under this Agreement. Records for non-expendable property acquired with funds under this Agreement shall be retained for five (5) years after final disposition of such property. Records for any displaced person must be kept for five (5) years after he/she has received final payment. Notwithstanding the above, if there is litigation, claims, audits, negotiations, or other actions that involve any of the records cited and that have started before the expiration of the five-year period, then such records must be retained until completion of the actions and resolution of all issues, or the expiration of the five-year period, whichever occurs later.

x) **Fiduciary Duty.** SUBRECIPIENT acknowledges that it has read the award conditions and certifications for ESG, that it understands and accepts those conditions and certifications, and that it agrees to comply with all the obligations, and be bound by any limitations applicable to COUNTY, as grantee, under those grant documents.

y) **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 grant 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 or to terminate this relationship including the original Agreement and all associated amendments.

z) **Program Income**. SUBRECIPIENT shall report monthly all program income as defined at 2 CFR 200.80 generated by activities carried out with ESG funds made available under this Agreement. By way of further limitations, SUBRECIPIENT may use such income during the Agreement period for activities permitted under this Agreement and shall reduce request for additional funds by the amount of any such program income balances on hand. All unused program income shall be returned to COUNTY at the end of the Agreement period.

11. 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, "Equal Employment Opportunity" 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 2 CFR Part 200 as applicable to SUBRECIPIENT. See Exhibit A for additional requirements.

b) **Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251 et seq.).** SUBRECIPIENT agrees that if this Agreement is in excess of $150,000, the recipient agrees to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. 7401 et seq., and the Federal Water Pollution Control Act, as amended 33 U.S.C. 1251 et seq. Violations shall be reported to the awarding Federal Department and the appropriate Regional Office of the Environmental Protection Agency.

c) **Lead-Based Paint**. SUBRECIPIENT agrees to comply with the Lead-Based Paint Poisoning Prevention Act and implementing regulations at 24 CFR Part 35.

d) **Drug-Free Workplace Act of 1988**. SUBRECIPIENT agrees to comply with the requirements of 24 CFR Part 24 concerning the Drug-Free Workplace Act of 1988 by administering in good faith a policy designed to ensure that its facilities are free from the illegal use, possession, or distribution of drugs or alcohol by its beneficiaries.

e) **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.

f) **Conflict Resolution.** If potential, actual or perceived conflicts are discovered among federal, state and local statutes, regulations, administrative rules, executive orders, ordinances or other laws applicable to the Services under the Agreement, SUBRECIPIENT may in writing request COUNTY to resolve the conflict. SUBRECIPIENT shall specify if the conflict(s) create a problem for the design or other Services required under the Agreement. COUNTY shall undertake reasonable efforts to resolve the issue but is not required to deliver any specific answer or product. SUBRECIPIENT shall remain obligated to independently comply with all applicable laws and no action by COUNTY shall be deemed a guarantee, waiver, or indemnity for non-compliance with any law.

g) **Disclosure of Information.** Any confidential or personally identifiable information (2 CFR 200.82) acquired by SUBRECIPIENT during the execution of the project should not be disclosed during or upon termination or expiration of this Agreement for any reason or purpose without the prior written consent of COUNTY. SUBRECIPIENT further agrees to take reasonable measures to safeguard such information (2 CFR 200.303) and to follow all applicable federal, state and local regulations regarding privacy and obligations of confidentiality.

h) **Mileage reimbursement.** If mileage reimbursement is authorized in SUBRECIPIENT budget or by the written approval of COUNTY, mileage must be paid at the rate established by SUBRECIPIENT'S written policies covering all organizational mileage reimbursement or at the IRS mileage rate at the time of travel, whichever is lowest.

12. Federal and State Procurement Standards

a) All procurement transactions, whether negotiated or competitively bid and without regard to dollar value, shall be conducted in a manner so as to provide maximum open and free competition. All sole-source procurements must receive prior written approval from COUNTY in addition to any other approvals required by law applicable to SUBRECIPIENT. Justification for sole-source procurement

should include a description of the project and what is being contracted for, an explanation of why it is necessary to contract noncompetitively, time constraints and any other pertinent information. Interagency agreements between units of government are excluded from this provision. SUBRECIPIENT shall comply with the procurement standards applying to subrecipients under this Federal award contained in 2 CFR 200.318-326.

b) COUNTY's performance under the Agreement is conditioned upon SUBRECIPIENT's compliance with, and SUBRECIPIENT shall comply with, the obligations applicable to public contracts under the Oregon Public Contracting Code and applicable Local Contract Review Board rules, which are incorporated by reference herein.

c) SUBRECIPIENT must maintain written standards of conduct covering conflicts of interest and governing the performance of its employees engaged in the selection, award and administration of contracts. If SUBRECIPIENT has a parent, affiliate, or subsidiary organization that is not a state, local government, or Indian tribe, SUBRECIPIENT must also maintain written standards of conduct covering organizational conflicts of interest. SUBRECIPIENT shall be alert to organizational conflicts of interest or non-competitive practices among contractors that may restrict or eliminate competition or otherwise restrain trade. Contractors that develop or draft specifications, requirements, statements of work, and/or Requests for Proposals ("RFP") for a proposed procurement must be excluded by SUBRECIPIENT from bidding or submitting a proposal to compete for the award of such procurement. Any request for exemption must be submitted in writing to COUNTY.

d) SUBRECIPIENT agrees that, to the extent they use contractors or subcontractors, such recipients shall use small, minority, women-owned or disadvantaged business concerns and contractors or subcontractors to the extent practicable.

13. **General Agreement Provisions**.

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 indemnify and hold COUNTY and its commissioners, officers, employees, and agents 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 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 the COUNTY evidence of Professional Liability Insurance in the amount of not less than $1,000,000 combined single limit per occurrence/$2,000,000 general annual aggregate for malpractice or errors and omissions coverage 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) **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, commissioners, officers, and employees" as an additional insured.

5) **Notice of Cancellation.** There shall be no cancellation, material change, exhaustion of aggregate limits or intent not to renew insurance coverage without 60 days written notice to COUNTY. Any failure to comply with this provision will not affect the insurance coverage provided to COUNTY. The 60 days-notice of cancellation provision shall be physically endorsed on to the policy.

6) **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.

7) **Certificates of Insurance.** As evidence of the insurance coverage required by this Agreement, SUBRECIPIENT shall furnish a Certificate of Insurance to COUNTY. COUNTY and its officers must be named as an additional insured on the Certificate of Insurance. No Agreement shall be in effect until the required certificates have been received, approved, and accepted by COUNTY. The certificate will specify that all insurance-related provisions within the Agreement have been complied with. A renewal certificate will be sent to COUNTY 10 days prior to coverage expiration.

8) **Primary Coverage Clarification**. SUBRECIPIENT coverage will be primary in the event of a loss.

9) **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.

d) **Subagreement**. SUBRECIPIENT shall not enter into any subagreements with any agency or individual in the performance of this Agreement.

e) **Binding Effect.** This Agreement shall be binding on all parties hereto, their heirs, administrators, executors, successors and assigns.

f) **Integration**. This Agreement contains the entire Agreement between COUNTY and SUBRECIPIENT and supersedes all prior written or oral discussions or Agreements.

14. Other Federal Requirements

a) The requirements in 24 CFR part 5, subpart A are applicable, including the nondiscrimination and equal opportunity requirements at 24 CFR 5.105(a). Section 3 of the Housing and Urban Development Act of 1968, 12 U.S.C. 1701u, and implementing regulations at 24 CFR part 135 apply, except that homeless individuals have priority over other Section 3 residents in accordance with § 576.405(c).

b) **Hatch Act**. SUBRECIPIENT agrees that no funds provided, nor personnel employed under this Agreement, shall be in any way or to any extent engaged in the conduct of political activities in violation of Chapter 15 of the Title V United States Code.

c) **Affirmative outreach**. SUBRECIPIENT must make known that use of the facilities, assistance, and services are available to all on a nondiscriminatory basis. If it is unlikely that the procedures that the recipient or subrecipient intends to use to make known the availability of the facilities, assistance, and services will to reach persons of any particular race, color, religion, sex, age, national origin, familial status, or disability who may qualify for those facilities and services, the recipient or subrecipient must establish additional procedures that ensure that those persons are made aware of the facilities, assistance, and services. SUBRECIPIENT must take appropriate steps to ensure effective communication with persons with disabilities including, but not limited to, adopting procedures that will make available to interested persons information concerning the location of assistance, services, and facilities that are accessible to persons with disabilities. Consistent with Title VI and Executive Order 13166, SUBRECIPIENT is also required to take reasonable steps to ensure meaningful access to programs and activities for limited English proficiency ("LEP") persons.

d) **Uniform Administrative Requirements**. The requirements of 2 CFR part 200 apply to SUBRECIPIENT; program income is to be used as the nonfederal share under 2 CFR 200.307(e). These regulations include allowable costs and non-Federal audit requirements.

e) Religious Organization. SUBRECIPIENT agrees that funds provided under this Agreement will not be utilized for religious activities, to promote religious interest, or for the benefit of a religious organization in accordance with the Federal regulations specified in 24 CFR 576.406.

f) **Environmental review responsibilities**.

a. Activities under this part are subject to environmental review by HUD under 24 CFR Part 50. SUBRECIPIENT shall supply all available, relevant information necessary for COUNTY to perform for each property any environmental review required by 24 CFR part 50. At the instruction of COUNTY SUBRECIPIENT may be required to carry out mitigating measures required by COUNTY or select alternate eligible property. COUNTY may eliminate from consideration any application that would require an Environmental Impact Statement ("EIS").

b. SUBRECIPIENT, or any contractor of SUBRECIPIENT, may not acquire, rehabilitate, convert, lease, repair, dispose of, demolish, or construct property for a project under this part, or commit or expend HUD or local funds for eligible activities under this part, until COUNTY has performed an environmental review under 24 CFR part 50 and SUBRECIPIENT has received COUNTY approval of the property.

g) **Davis-Bacon Act**. The provisions of the Davis-Bacon Act (40 U.S.C. 276a to 276a–5) do not apply to the ESG program.

h) **Procurement of Recovered Materials**. SUBRECIPIENT and its contractors must comply with Section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act. The requirements of Section 6002 include procuring only items designated in guidelines of the Environmental Protection Agency ("EPA") at 40 CFR part 247 that contain the highest percentage of recovered materials practicable, consistent with maintaining a satisfactory level of competition, where the purchase price of the item exceeds $10,000 or the value of the quantity

acquired by the preceding fiscal year exceeded $10,000; procuring solid waste management services in a manner that maximizes energy and resource recovery; and establishing an affirmative procurement program for procurement of recovered materials identified in the EPA guidelines.

i) **Displacement, Relocation, and Acquisition**. Consistent with the other goals and objectives of ESG, SUBRECIPIENT must assure that they have taken all reasonable steps to minimize the displacement of persons (families, individuals, businesses, nonprofit organizations, and farms) as a result of a project assisted under ESG.

j) **Temporary relocation not permitted**. No tenant-occupant of housing (a dwelling unit) that is converted into an emergency shelter may be required to relocate temporarily for a project assisted with ESG funds, or be required to move to another unit in the same building/complex. When a tenant moves for a project assisted with ESG funds under conditions that trigger the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 ("URA"), 42 U.S.C. 4601–4655, as described in paragraph (c) of this section, the tenant should be treated as permanently displaced and offered relocation assistance and payments consistent with that paragraph.

k) **Non-displacement.** SUBRECIPIENT agrees to minimize displacement and comply with (a) the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, as amended and implementing regulations at 49 CFR Part 24 and (b) the requirements of 24 CFR 576.408 governing the ESG program. SUBRECIPIENT shall provide relocation assistance to persons (families, individuals, businesses, nonprofit organizations, and farms) that are displaced as a direct result of acquisition, rehabilitation, demolition or conversion for an ESG-assisted project. SUBRECIPIENT also agrees to comply with applicable COUNTY ordinances, resolutions, and policies concerning the displacement of persons from their residences. Any activity which may result in a displaced person (defined in paragraph l. of this section) must be reported to COUNTY prior to the commencement of the activity. COUNTY shall determine the relocation assistance as provided in 24 CFR 576.408(c). All such assistance shall be subtracted from the ESG funds provided to SUBRECIPIENT.

l) **Displaced Person**. For purposes of paragraph k. of this section, the term "displaced person" means any person (family, individual, business, nonprofit organization, or farm, including any corporation, partnership, or association) that moves from real property, or moves personal property from real property, permanently, as a direct result of acquisition, rehabilitation, or demolition for a project assisted under the ESG program. This includes any permanent, involuntary move for an assisted project, including any permanent move from the real property.

m) **Real property acquisition requirements**. The acquisition of real property, whether funded privately or publicly, for a project assisted with ESG funds is subject to the URA and Federal government wide regulations at 49 CFR Part 24, subpart B.

n) **Appeals**. A person who disagrees with COUNTY'S (or SUBRECIPIENT'S, if applicable) determination concerning whether the person qualifies as a displaced person, or the amount of relocation assistance for which the person may be eligible, may file a written appeal of that determination with the recipient under 49 CFR 24.10. A low-income person who disagrees with the recipient's determination may submit a written request for review of that determination by the appropriate HUD field office.

15. Civil Rights

a) **Compliance**. SUBRECIPIENT agrees to comply with Title VI of the Civil Rights Act of 1964 as amended, Title VIII of the Civil Rights Act of 1968 as amended, Section 104(b) and Section 109 of Title I of Housing and Community Development Act of 1974 as amended, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, Executive Order 11063, and with Executive Order 11246 as amended by Executive Order 11375 and 12086.

b) **Nondiscrimination**. SUBRECIPIENT will not discriminate against any employee or applicant for employment because of race, color, creed, religion, ancestry, nation origin, sex, disability, or other handicap, age, marital/familial status, or status with regard to public assistance. SUBRECIPIENT will take affirmative action to insure that all employment practices are free from such discrimination. Such employment practices include but are not limited to the following: hiring, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff, termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship. SUBRECIPIENT agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by COUNTY setting forth the provisions of this nondiscrimination clause.

c) **Section 504**. SUBRECIPIENT agrees to comply with any Federal regulations issued pursuant to compliance with Section 504 of the Rehabilitation Act of 1974, which prohibits discrimination against the handicapped in any Federally-assisted program. COUNTY shall provide SUBRECIPIENT with any guidelines necessary for compliance with that portion of the regulations in force during the term of this Agreement.

16. Affirmative Action

a) **Plan**. SUBRECIPIENT agrees that it shall be committed to carry out pursuant to COUNTY's specifications an Affirmative Action Program in keeping with the principles as provided in President's Executive Order 11246 of September 24, 1965.

b) **Women and Minority Business Enterprises**. SUBRECIPIENT will use its best efforts to afford minority- and women-owned business enterprises the maximum practicable opportunity to participate in the performance of this Agreement. As used in this Agreement, the term "minority and female business enterprise" means a business at least fifty-one (51) percent owned and controlled by minority group members or women. For the purpose of this definition, "minority group members" are Afro-Americans, Spanish-speaking, Spanish surnamed or Spanish-heritage Americans, Asian-Americans, and American Indians. SUBRECIPIENT may rely on written representation by businesses regarding their status as minority and female business enterprises in lieu of an independent investigation.

c) **Access to Records**. SUBRECIPIENT shall furnish and cause each of its own subrecipients or subcontractors to furnish all information and reports required hereunder and will permit access to its books, records and accounts by COUNTY, HUD or its agent, or other authorized Federal officials for purposes of investigation to ascertain compliance with the rules, regulations, and provisions stated herein.

d) **Notifications**. SUBRECIPIENT will send to each labor union or representative of workers with which it has a collective bargaining agreement or other Agreement or understandings, a notice, provided by COUNTY, advising the labor union or worker's representative of SUBRECIPIENT's commitments hereunder, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

e) **EEO/AA Statement**. SUBRECIPIENT will, in all solicitations or advertisements for employees placed by or on behalf of SUBRECIPIENT, state that it is an Equal Opportunity or Affirmative Action employer.

f) **Subcontracting Provisions**. SUBRECIPIENT will include the provisions of Paragraph 23, Civil Rights, and 24, Affirmative Action, in every subcontract or purchase orders, specifically or by reference, so that such provisions will be binding upon each of its subrecipients or subcontractors.

17. Employment Restrictions

a) **Prohibited Activity**. SUBRECIPIENT is prohibited from using funds provided herein or personnel employed in the administration of the program for: political activities, sectarian or religious activities, lobbying, political patronage, and nepotism activities.

b) **Labor Standards**. SUBRECIPIENT agrees to comply with the requirements of the Secretary of Labor in accordance with Davis-Bacon Act as amended, the provisions of Agreement: Work Hours and Safety Standards Act, the Copeland "Anti-Kickback" Act and all other applicable Federal, state and local laws and regulations pertaining to labor standards insofar as those acts apply to the performance of this Agreement. SUBRECIPIENT shall maintain documentation which demonstrates compliance with hour and wage requirements of this part. Such documentation shall be made available to COUNTY for review upon request. SUBRECIPIENT agrees that, except with respect to the rehabilitation or construction of residential property containing less than eight (8) units, all Agreements engaged under Agreements in excess of $2,000.00 for construction, renovation or repair work financed in whole or in part with assistance provided under this Agreement, shall comply with Federal requirements adopted by COUNTY pertaining to such Agreements and with the applicable requirements of the regulations of the Department of Labor, under 29 CFR Parts 1, 3, 5 and 7 governing the payment of wages and ratio of apprentices and trainees to journey-workers; provide, that if wage rates higher than those required under the regulations are imposed by state or local laws, nothing hereunder is intended to relieve SUBRECIPIENT of its obligation, if any, to require payment of the higher wage. SUBRECIPIENT will cause or require to be inserted in full, in all Agreements subject to such regulations, provisions meeting the requirements of this paragraph.

c) Job Training and Employment for Low-income Residents -Section 3

i. **Compliance**. Compliance with the provisions of Section 3, the regulations set forth in 24 CFR 135, and all applicable rules and orders issued hereunder prior to the execution of this Agreement, shall be a condition of the Federal financial assistance provided under this Agreement and binding upon COUNTY, SUBRECIPIENT, and any of SUBRECIPIENT's subrecipients and subcontractors. Failure to fulfill these requirements shall subject the COUNTY, SUBRECIPIENT, and any of SUBRECIPIENT's subrecipients and subcontractors, their successors and assigns, to those sanctions specified by the Agreement through which Federal assistance is provided. SUBRECIPIENT certifies and agrees that no agreements or disability exist which would prevent compliance with these requirements.

ii. SUBRECIPIENT further agrees to comply with these "Section 3" requirements and to include the following language in all subcontracts executed under this Agreement:

"The work to be performed under this Agreement is a project assisted under a program providing direct Federal financial assistance from HUD and is subject to the requirements of Section 3 of the Housing and Community Development Act of 1968, as amended, 12 U.S.C. 1701. Section 3 requires that to the greatest extent feasible opportunities for training and employment be given to low-and very low-income residents of the project area and Agreements for work in connection with the project be awarded to business concerns that provide economic opportunities for low- and very low-income persons residing in the metropolitan area in which the project is located."

iii. SUBRECIPIENT further agrees to ensure that opportunities for training and employment arising in connection with a housing rehabilitation, housing construction, or other public construction project are given to low- and very low-income persons residing with in the metropolitan area in which the ESG funded project is located; where feasible, priority should be given to low- and very low-income persons within the service area of the project or neighborhood in which the project is located, and to low- and very low-income participants in other HUD programs; and award Agreements for work undertaken in connection to housing rehabilitation, housing construction, or other public construction project are given to business concerns that provide economic opportunities for low- and very low-income persons residing within the metropolitan

area in which ESG-funded project is located; where feasible, priority should be given to business concerns which provide economic opportunities to low- and very low-income residents within the service area or neighborhood in which the project is located, and to low- and very low-income participants in other HUD programs.

iv. SUBRECIPIENT certifies and agrees that no agreements or legal incapacity exists which would prevent compliance with these requirements.

v. **Notifications**. SUBRECIPIENT agrees to send to each labor organization or representative of worker with which it has a collective bargaining agreement or other Agreement or understanding, if any, a notice advising said labor organization or worker's representative of its commitments under this Section 3 clause and shall post copies of the notice in conspicuous places available to employees and applicants for employment or training.

vi. **Subcontracts**. SUBRECIPIENT will include this Section 3 clause in every subcontract and will take appropriate action pursuant to the subcontract upon a finding that the subcontract is in violation of regulations issued by the grantor agency. SUBRECIPIENT will not subcontract with any entity where it has notice or knowledge that the latter has been found in violation of regulations under 24 CFR 135 and will not let any subcontract unless the entity has first provided it with a preliminary statement of ability to comply with the requirements of these regulations.

18. **Assignment.** This Agreement may not be assigned in whole or in part without the prior express written approval of COUNTY.

19. **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.

20. **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.

21. **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 without giving effect to the conflict of law provisions thereof. 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.

22. **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.

23. **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.

24. **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.

(Signature Page Follows)

SIGNATURE PAGE TO SUBRECIPIENT GRANT AGREEMENT

AGREED as of the Effective Date.

CLACKAMAS COUNTY

Commissioner: Jim Bernard, Chair
Commissioner: Sonya Fischer
Commissioner: Ken Humbertson
Commissioner: Paul Savas
Commissioner: Martha Schrader

Signing on Behalf of the Board,

By: _____
Richard Swift, Director
Health, Housing and Human Services

By: _____
Recording Secretary

Dated: _____

Approved to Form

By: _____
County Counsel

Dated: _____

NORTHWEST HOUSING ALTERNATIVES, INC.

By: Trell Anderson
Trell Anderson, Executive Director

Dated: 8/26/19

- Exhibit A: SUBRECIPIENT Statement of Program Objectives & Requirements
- Exhibit A.1 SUBRECIPIENT Scope of Work
- Exhibit B: SUBRECIPIENT *Program Budget*
- Exhibit C: Lobbying Certificate
- Exhibit D: Required Financial Reporting and Reimbursement Request
- Exhibit E: Subrecipient Performance Reporting
- Exhibit F: Required Certifications
- Exhibit G: Final Financial Report

- Attachment A: ESG Policies

Health, Housing & Human Services
CLACKAMAS COUNTY

COPY

Richard Swift
Director

September 5, 2019

Board of County Commissioners
Clackamas County

Members of the Board:

Approval to Apply for Grants from Portland General Electric (PGE) Drive Change Fund to advance the electrification of the elderly & disabled transportation network

Purpose/Outcomes	Agreement with PGE to provide funding for project specific electric vehicles and charging stations to enhance transportation services to seniors and/or people with disabilities residing in Clackamas County.
Dollar Amount and Fiscal Impact	The maximum grant award is $575,000. The contract would be funded by Oregon Clean Fuels program administered by Oregon Dept. of Environmental Quality.
Funding Source	Oregon Clean Fuels program administered by Oregon Dept. of Environmental Quality - no County General Funds are involved.
Duration	Anticipated award September 1, 2019 and terminates on December 31, 2020
Previous Board Action	None
Strategic Plan Alignment	1. This funding aligns with the strategic priority to increase self-sufficiency for our clients. 2. This funding aligns with the strategic priority to ensure safe, healthy and secure communities by addressing needs of older adults in the community.
Contact Person	Brenda Durbin, Director, Social Services Division 503-655-8641
Contract No.	N/A

BACKGROUND:
The Social Services Division of the Health, Housing, and Human Services Department requests approval to apply for grant funds from the Portland General Electric (PGE) Drive Change Fund to enhance electric vehicle options in rural areas of Clackamas County that provide services to seniors, persons with disabilities and low income households. The county proposes placing charging locations at two senior centers located in Molalla and Estacada, along with providing an electric, or electric hybrid, vehicle for each centers. These vehicles would be used to provide rides to vulnerable citizens in their communities. In addition, Social Services proposes purchasing two electric, or hybrid, vehicles for use in the Transportation Reaching People (TRP) program. TRP provides rides to seniors and persons with disabilities county-wide to medical appointments and other essential services that allow them to remain in their homes and communities throughout Clackamas County.

Additional for this project, Social Services would like to purchase two electric vehicles for use by case managers who provide home and community based services to vulnerable residents' county wide, along with updating the charging station infrastructure on the County's Red Soils campus and adding two charging stations.

Social Services is working with Fleet Services, Facilities Management and DTD-Sustainability & Solid Waste on this project to coordinate county campus improvements as well as coordination to work toward the County's objective of reducing emissions and providing alternative to traditional transportation modes regionally.

The grant would provide funding for up to (6) electric or electric hybrid vehicles with (4) new charging stations for these vehicles and improvements to (4) existing charging stations at the Red Soils Campus. No County General Funds are involved. The award would fund capital equipment costs, all costs associated with the charging stations, projected maintenance costs for up to (3) years, network/licenses fees for charging updates for up to (3) years, project management costs and administration costs at or below 10%. The PGE funding, if awarded, will provide increased transportation options for Clackamas County Social Services Division TRP and two rural community partners while decreasing emissions of these programs.

RECOMMENDATION:
We recommend the approval to apply for this grant and further recommend the acceptance of the award if funded, and that Richard Swift be authorized to sign all documents necessary to accomplish this action on behalf of the Board of Commissioners.

Respectfully submitted,

Rachel A. Cook, H3S Dept Director/FOR

Richard Swift, Director
Health Housing & Human Services Dept.

PGE Drive Change Fund Certification

Complete and submit this certification as an attachment to the Drive Change Fund Application.

As an authorized representative for the applicant organization:

- *I certify that I have reviewed the applicant as well as the award recipient requirements and guidelines, understand that should this project be awarded funding, my organization and project will be able to meet the technical requirements and award recipient requirements as described on the Portland General Electric website.*
- *I attest that the information provided above responding to this application is both accurate and current, and that funding described in this application as secured has actually been secured.*
- *If new or upgraded electrical service is required, I attest that a service request has been submitted to Portland General Electric or the electric utility that serves the site where the infrastructure will be located.*
- *I understand that submitting an application in no way obligates Portland General Electric to provide funding and that funds are distributed at the sole discretion of Portland General Electric.*

Signature: _____ Date: _____

Printed Name: Richard Swift

Title: Director, Health Housing & Human Services Dept.

Company: Clackamas County

Phone Number: 503-650-5694

If this project includes onsite infrastructure, and the project applicant is not the property owner, the property owner must sign below.

As the property owner at [address]_____, I certify that I have reviewed the application, along with supporting documentation, and that I support the project as described.

Signature: _____ Date: _____

Printed Name: _____

Title: _____

Company: _____

Phone Number: _____

Grant Application Lifecycle Form

Use this form to track your potential grant from conception to submission.

Sections of this form are designed to be completed in collaboration between department program and fiscal staff.

** CONCEPTION **

Note: The processes outlined in this form are not applicable to disaster recovery grants.

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

Application for: ☐ Subrecipient funds ☑ Direct Grant

Lead Department: H3S/SSD

Grant Renewal? ☐ Yes ☑ No

If renewal, complete sections 1, 2, & 4 only

Name of Funding Opportunity: PGE Drive Change Fund

Funding Source: ☐ Federal ☐ State ☑ Local: Portland General Electric

Requestor Information (Name of staff person initiating form): Stefanie Reid-Danielson

Requestor Contact Information: stefaniere@clackamas.us 503-655-8330

Department Fiscal Representative: Same

Program Name or Number (please specify): PGE Grant

Brief Description of Project:

This grant will providing funding to purchase up to (6) electric, or plug-in hybrid, vehicles. (2) will be used to enhance the fleet of the Transportation Reaching People Program. (2) will be used by Social Services' staff to conduct home visits. (2) would be outstationed at the Estacada and Molalla community centers for use in providing transportation services for older adults. The grant also includes funding for (2) additional charging stations and upgrades to (4) stations on the County Red Soils Campus and (1) station at each community center.

Name of Funding (Granting) Agency: Portland General Electric

Agency's Web Address for Grant Guidelines and Contact Information:

https://www.portlandgeneral.com/business/make-my-business-more-sustainable/electric-fleets-charging-stations/the-pge-drive-change-fund

OR

Application Packet Attached: ☐ Yes ☐ No

Completed By: Stefanie Reid-Danielson 8/27/19

Date

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

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

☑ Competitive Grant ☐ Non-Competing Grant ☐ Other

Funding Agency Award Notification Date: After 8/30/19

CFDA(s), If applicable: N/A

Announcement Date: 6/13/19

Announcement/Opportunity #:

Grant Category/Title: PGE Drive Change Fund

Max Award Value: $ 575,000

Allows Indirect/Rate: N/A

Match Requirement: N/A

Application Deadline: 8/30/19

Other Deadlines:

Grant Start Date: Upon Award

Other Deadline Description:

Grant End Date: 12 months from Award

Projects must be in service within 12 months of award

Completed By:

Program Income Requirement: None

Pre-Application Meeting Schedule:

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 support the Department and/or Division's Mission/Purpose/Goals?

These funds would increase the Divisions ability to provide transportation services to older adults and people with disabilities, thus increasing their independence and quality of life. The grant would also support the County's goal of decreasing fossil fuel emissions.

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

At this time there are no community partners better suited to take the lead. This project is being developed in close coordination with the Estacada Community Center & the Molalla Adult Community Center.

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

The objective of the grant is to increase the electric vehicle infrastructure in the PGE service area, with a focus on low income and rural communities. This objective will be met by prioritizing two rural communities in Clackamas County, and providing enhanced services to older adults and persons with a disability.

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

These funds will support existing transportation programs operated by the county and our community partners. Funds will also expand the number of electric and hybrid vehicles available to Social Services' staff.

Organizational Capacity:

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

Yes, Social Services Administrations has sufficient staff to manage this grant.

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

This project is a partnership with the Estacada Community Center and the Molalla Adult Community Center, operated by Foothills Community Church. Their roles are to utilize the newly developed electric vehicle infrastructure once it is in place. The County Departments that are also participating are Fleet Services, Facilities, and Sustainability and Solid Waste. Their roles are to integrate this new infrastructure into existing plans for reducing the county's carbon footprint.

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, this grant would 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.)?

This grant will not create a new program but will enhance existing programs.

Collaboration

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

Fleet Services, Facilities, and DTD-Sustainability & Solid Waste.

Reporting Requirements

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

Quarterly reporting as the project progresses followed by a completion report after vehicles are purchased and infrastructure installation is completed. After the completion report is submitted, an annual report will be due for 3 years for the vehicles and up to 10 years for the charging infrastructure.

2. How will grant 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?

Performance will be measured by rides delivered, miles driven and cost per mile/hour when compared to existing vehicles. For the charging stations, we will developing a reporting relationship with our back end vendor who is operating the stations to determine the use of the stations by the following groups: fleet vehicles, county employees, and members of the general public. Success will be measured by increased use in each of these groups. Data sources for transportation already exists and are housed within Social Services. Data sources for Charging stations will be developed and housed within Social Services as well.

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

see response to #1 above.

Fiscal

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

Yes, this grant will provide up to $575,000 in additional electric vehicle infrastructure in three regions in the county. The costs of administering the grant are minimal.

2. Are other revenue sources required? Have they already been secured?

No other revenue sources are required.

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

No match is required.

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

Up to 10% of Administrate costs will be included in addition to the project management costs.

Program Approval:

Teresa Christopherson	8/22/19	Signature
Name (Typed/Printed)	Date	

** 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)		
Brenda Durbin	8-27-19	
Name (Typed/Printed)	Date	Signature

DEPARTMENT DIRECTOR or ELECTED OFFICIAL (or designee, if applicable)		
Name (Typed/Printed)	Date	Signature

FINANCE GRANT MANAGER *(or designee, if applicable; FOR FEDERALLY-FUNDED APPLICATIONS ONLY)*		
Jeff Aldridge	8/27/19	Jeff Aldridge
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: _____

_____

County Administration Attestation

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

Health, Housing & Human Services
CLACKAMAS COUNTY

COPY

Richard Swift
Director

September 5, 2019

Board of County Commissioners
Clackamas County

Members of the Board:

Approval to Apply to Oregon Department of Veterans' Affairs for
FY 2020 Distribution of Funds

Purpose/Outcomes	Oregon Department of Veterans' Affairs will continue to provide operational funding for the County Veterans' Services Office.
Dollar Amount and Fiscal Impact	$269,398
Funding Source	Oregon Department of Veterans' Affairs and County General Funds.
Duration	July 1, 2019 through June 30, 2020
Previous Board Action	None.
Strategic Plan Alignment	1. This funding aligns with Social Services Division's strategic priority to help people in need live with self-reliance and independence. 2. This funding aligns with the County's strategic priority to ensure safe, healthy and secure communities.
Counsel Review	N/A
Contact Person	Brenda Durbin, Director – Social Services Division – (503) 655-8641
Contract No.	N/A

BACKGROUND:
The Social Services Division of the Health, Housing and Human Services Department operates the Veterans' Service Office for Clackamas County. Approval to Apply for Oregon Department of Veterans' Affairs (ODVA) FY2020 funding is requested to receive operational funding for the County Veterans' Services Office (CVSO). The expected result over time is that more Clackamas County veterans will obtain service connected disability, needs based pension, Veterans' Affairs (VA) health care and other benefits earned through military service. ODVA funding in FY18-19 resulted in 952 initial claims filed, more than $11,757,000 in claims awarded, and 31 outreach sessions conducted reaching more than 350 veterans and veteran service providers. The dollar amount will increase as VA processes more filed claims. Staff have also engaged regularly with the Veterans Advisory Council and Homeless Veterans Coordination Team. Two staff attended the National CVSO conference. Funding term is July 1, 2019 to June 30, 2020. A total of $598,122 County General Funds are budgeted and are included on the application. A portion of this is rollover funds that will be incorporated into a budget adjustment in October 2019.

RECOMMENDATION:
Staff recommends the approval of the grant application, and that Gary Schmidt, County Administrator, be authorized to sign all documents necessary on behalf of the Clackamas County Board of Commissioners.

Respectfully submitted,

Rodney A Cook, H3S Deputy Director, For

Richard Swift, Director
Health, Housing and Human Services Department

Grant Application Lifecycle Form

Use this form to track your potential grant from conception to submission.

Sections of this form are designed to be completed in collaboration between department program and fiscal staff.

**** CONCEPTION ****

Note: The processes outlined in this form are not applicable to disaster recovery grants.

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

Application for: ☐ Subrecipient funds ☑ Direct Grant

Lead Department: H3S/SSD

Grant Renewal? ☑ Yes ☐ No

If renewal, complete sections 1, 2, & 4 only

Name of Funding Opportunity: Oregon Dept of Veterans' Affairs (ODVA) County Application

Funding Source: ☐ Federal ☑ State ☐ Local:

Requestor Information (Name of staff person initiating form): Erika Silver

Requestor Contact Information: x5725

Department Fiscal Representative: Jennifer Snook

Program Name or Number (please specify): Clackamas County Veterans' Service Office (CVSO)

Brief Description of Project:

This grant provides core operational funding for the County Veterans' Services Office. Last year staff met with 2,040 veterans and filed 952 initial claims, 91 appeals and helped 50 veterans apply for VA health care. 900 claims were granted. In total the efforts of the Clackamas County Veterans Service Office brought in more than $11,757,000 in new money for Clackamas County veterans. This figure will increase as the VA continues to process filed claims.

Name of Funding (Granting) Agency: Oregon Dept. of Veterans' Affairs

Agency's Web Address for Grant Guidelines and Contact Information:

https://www.oregon.gov/odva/Connect/Pages/Grants.aspx

OR

Application Packet Attached: ☐ Yes ☑ No

Completed By: Erika Silver and Jennifer Snook 08/28/2019

Date

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

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

☐ Competitive Grant ☑ Non-Competing Grant ☐ Other

Funding Agency Award Notification Date: 08/22/2019

CFDA(s), if applicable: N/A

Announcement Date: N/A

Announcement/Opportunity #: N/A

Grant Category/Title: N/A

Max Award Value: $269,398

Allows Indirect/Rate: N/A

Match Requirement: N/A

Application Deadline: 09/06/2019

Other Deadlines:

Grant Start Date: 07/01/2019

Other Deadline Description:

Need application signed by Gary Schmidt on BCC meeting date, 9-5-19, and returned same day to Soc. Services to meet grant deadline.

Grant End Date: 06/30/2019

Completed By: Jessica Diridoni

Program Income Requirement: low-income

Pre-Application Meeting Schedule:

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

Mission/Purpose:

1. How does the grant 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 grant? How will we meet these objectives?

4. Does the grant proposal 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 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, this grant would 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?

2. How will grant 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 grant?

Fiscal

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

2. Are other revenue sources required? Have they already been secured?

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 cover indirect costs? If yes, is there a rate cap? If no, can additional funds be obtained to support indirect expenses and what are they?

Program Approval:

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)		
Brenda Durbin	08/28/2019	FOR B.D.
Name (Typed/Printed)	Date	Signature

DEPARTMENT DIRECTOR (or designee, if applicable)		
Richard Swift	08/28/2019	
Name (Typed/Printed)	Date	Signature

FINANCE GRANT MANAGER *(or designee, if applicable; FOR FEDERALLY-FUNDED 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: 09/05/2019

OR

Policy Session Date: _____

County Administration Attestation

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

OREGON DEPARTMENT of VETERANS' AFFAIRS

COUNTY APPLICATION FOR ODVA FUNDS
FY: JULY 1, 2019 TO JUNE 30, 2020

This is a fillable form. Save the form to your computer, complete the form, print, sign, scan and send electronically.

A county must complete and submit this form along with the required documents listed below to the Oregon Department of Veterans' Affairs **no later than September 6, 2019** in order to receive state funds for the county's veteran services office. Please submit the documents to: CVSO-NSOFunding@ODVA.state.or.us.

SUBMIT TO: CVSO-NSOFunding@ODVA.state.or.us

CONTACT INFORMATION
Oregon Department of Veterans' Affairs Statewide Veteran Services
700 Summer St NE Salem, OR 97301-1285
For questions, please call: (503) 373-2090

TIME PERIOD
July 1, 2019 to June 30, 2020
COUNTY
Clackamas County

Budgeted Revenue for July 1, 2019 to June 30, 2020

ITEM	AMOUNT
County Funds	$ 521,184
*Carry forward of unspent budgeted funds from previous fiscal year *(if applicable)**	$ 76,938
ODVA Funds for 2019-20	$ 269,398
Other Funds *(Identify source)*	$
TOTAL REVENUE	$ 867,520

Budgeted Expenditures for July 1, 2019 to June 30, 2020

TOTAL BUDGETED EXPENDITURES	$ 867,520

(NOTE: Budgeted expenditures should match budgeted revenue)

Required Documents

- ☐ A copy of the approved budget for county veterans services office for the fiscal year 2020.
- ☐ A copy of the actual revenue and expenditures for the prior fiscal year, **if changed since submission with fourth quarter report.**
- ☑ *A description of the planned use of the carry-forward funds from FY 2019, if applicable.*
- ☐ If the county contracts for the provision of veteran services, attach a signed copy of the contract. N/A

CERTIFICATION
By my signature below, I hereby certify the following: the county is applying for funds for the county veterans' service office from the Oregon Department of Veterans' Affairs; the county will use these funds only as provided in ORS 406.310 and ORS 406.450 – 406.460; the county will comply with the Oregon Administrative Rules in Chapter 274, Division 030 that govern these funds; and the county will submit quarterly reports of activities and expenditures to the Oregon Department of Veterans' Affairs no later than the 30th day of the month following the end of each quarter.

Printed Name of County Commissioner/Judge		
Gary Schmidt		
Signature of County Commissioner/Judge		Date Signed
Title of Signer	Email Address	Telephone Number
County Administrator	gschmidt@clackamas.us	503-742-5908
ODVA APPROVED FOR FUNDING	Authorized Signature	Date

Rev FY 19-20

Clackamas County
Financial Management System
Revenue Comparison Report
Business Unit: CLACK
Budget Period: 2020
As of Accounting Period: 12 - June

Fund: 242 To 242
DeptID: 4341 To 4345
Program: 05280 To 05280

Report ID: GL002Z
Run Date: 8/27/2019
Run Time: 2:10:15 PM

Account		Estimated Revenue	Collections YTD	Balance	PCT Collected
FUND: 242 Social Services Fund					
DEPT: 4341 Community Action Agencies					
PROGRAM:	05280 Veterans Enhancement Grant				
	Grant Revenue				
332244	State Veterans' Office	13,083.00	0.00	-13,083.00	0.00
	Total Grant Revenue	**13,083.00**	**0.00**	**-13,083.00**	**0.00**
	Interfund Transfers				
390100	I/F Transfer From Fund 100	205,014.00	0.00	-205,014.00	0.00
	Total Interfund Transfers	**205,014.00**	**0.00**	**-205,014.00**	**0.00**
Total PROGRAM 05280		**218,097.00**	**0.00**	**-218,097.00**	**0.00**
Total DEPT 4341		**218,097.00**	**0.00**	**-218,097.00**	**0.00**

Rev FY 19-20

Clackamas County
Financial Management System
Revenue Comparison Report
Business Unit: CLACK
Budget Period: 2020
As of Accounting Period: 12 - June

Fund: 242 To 242
DeptID: 4341 To 4345
Program: 05280 To 05280

Report ID: GL002Z
Run Date: 8/27/2019
Run Time: 2:10:15 PM

Account		Estimated Revenue	Collections YTD	Balance	PCT Collected
FUND: 242 Social Services Fund					
DEPT: 4344 CAA Information & Assistance					
PROGRAM:	05280 Veterans Enhancement Grant				
	Carry Forward From 18-19	76,938			
	Grant Revenue				
332244	State Veterans' Office	~~272,108.00~~ 265,315	0.00	-272,108.00	0.00
	Total Grant Revenue	**272,108.00**	**0.00**	**-272,108.00**	**0.00**
	Interfund Transfers				
390100	I/F Transfer From Fund 100	~~377,315.00~~ 316,170	0.00	-377,315.00	0.00
	Total Interfund Transfers	**377,315.00**	**0.00**	**-377,315.00**	**0.00**
	Total PROGRAM 05280	**649,423.00** 649,423	**0.00**	**-649,423.00**	**0.00**
	Total DEPT 4344	**649,423.00**	**0.00**	**-649,423.00**	**0.00**
	Total FUND 242	**867,520.00**	**0.00**	**-867,520.00**	**0.00**
	Report Total	**867,520.00**	**0.00**	**-867,520.00**	**0.00**

EXP FY 19-20

Clackamas County
Financial Management System
Statement of Encumbrances and Expenditures
Business Unit: CLACK
Budget Period: 2020
As of Accounting Period: 12 - June

Fund: 242 To 242
DeptID: 4341 To 4345
Program: 05280 To 05280

Report ID: GL001Z
Run Date: 8/27/2019
Run Time: 2:28:25 PM

FUND: 242 Social Services Fund
DEPT: 4341 Community Action Agencies

PROGRAM: 05280 Veterans Enhancement Grant

Account		Appropriation	Encumbered	Expenditures	Avail. Balance	PCT Used
	Personal Services					
411100	Regular Full Time Employees	24,573.00	0.00	2,804.17	21,768.83	11.41
415000	Fringe Benefits	11,589.00	0.00	1,225.82	10,363.18	10.58
415020	Worker Compensation	3,535.00	0.00	0.00	3,535.00	0.00
	Total Personal Services	**39,697.00**	**0.00**	**4,029.99**	**35,667.01**	**10.15**
	Materials & Services					
435180	Casualty Insurance	2,852.00	0.00	0.00	2,852.00	0.00
438110	Office Rental	11,278.00	0.00	0.00	11,278.00	0.00
	Total Materials & Services	**14,130.00**	**0.00**	**0.00**	**14,130.00**	**0.00**
	Cost Allocation Charges					
477200	Division Indirect Costs	99,214.00	0.00	0.00	99,214.00	0.00
478101	Finance Allocated Costs	14,832.00	0.00	0.00	14,832.00	0.00
478102	Technology Services Alloc Cost	21,226.00	0.00	0.00	21,226.00	0.00
478103	Building Maintenance Allocated	11,196.00	0.00	0.00	11,196.00	0.00
478104	PGR Allocated Costs	3,138.00	0.00	0.00	3,138.00	0.00
478105	Records Management Allocated C	119.00	0.00	0.00	119.00	0.00
478106	Purchasing Services Allocated	525.00	0.00	0.00	525.00	0.00
478107	County Courier Allocated Cost	119.00	0.00	0.00	119.00	0.00
478111	Personnel Administration Alloc	8,705.00	0.00	0.00	8,705.00	0.00
478112	County Administration Allocate	2,505.00	0.00	0.00	2,505.00	0.00
478117	Mailroom Overhead	923.00	0.00	0.00	923.00	0.00
478201	Electric Utility Allocation	1,100.00	0.00	0.00	1,100.00	0.00
478202	Natural Gas Utility Allocation	106.00	0.00	0.00	106.00	0.00
478203	Water Utility Allocation	407.00	0.00	0.00	407.00	0.00
478204	Trash Removal Allocation	155.00	0.00	0.00	155.00	0.00
	Total Cost Allocation Charges	**164,270.00**	**0.00**	**0.00**	**164,270.00**	**0.00**
	Total PROG 05280	**218,097.00**	**0.00**	**4,029.99**	**214,067.01**	**1.85**
	Total DEPT 4341	**218,097.00**	**0.00**	**4,029.99**	**214,067.01**	**1.85**

EXP FY- 19-20

Clackamas County
Financial Management System
Statement of Encumbrances and Expenditures
Business Unit: CLACK
Budget Period: 2020
As of Accounting Period: 12 - June

Fund: 242 To 242
DeptID: 4341 To 4345
Program: 05280 To 05280

Report ID: GL001Z
Run Date: 8/27/2019
Run Time: 2:28:25 PM

FUND: 242 Social Services Fund
DEPT: 4344 CAA Information & Assistance

PROGRAM: 05280 Veterans Enhancement Grant

Account		Appropriation	Encumbered	Expenditures	Avail. Balance	PCT Used
	Personal Services					
411100	Regular Full Time Employees	316,314.00	0.00	35,959.14	280,354.86	11.37
413000	Temporary Workers	71,262.00	0.00	6,737.09	64,524.91	9.45
415000	Fringe Benefits	226,367.00	0.00	27,145.46	199,221.54	11.99
	Total Personal Services	**613,943.00**	**0.00**	**69,841.69**	**544,101.31**	**11.38**
	Materials & Services					
421100	General Office Supplies	1,500.00	0.00	0.00	1,500.00	0.00
421110	Postage	1,250.00	0.00	0.00	1,250.00	0.00
421210	Computer Hardware/Software-Non	7,593.00	0.00	3,143.00	4,450.00	41.39
432100	Telephone	5,500.00	0.00	0.00	5,500.00	0.00
432400	Advertising	1,000.00	0.00	0.00	1,000.00	0.00
433100	Travel & Per Diem (NO MILEAGE)	5,500.00	0.00	106.50	5,393.50	1.94
433110	Mileage Reimbursement	4,500.00	0.00	317.84	4,182.16	7.06
434100	Printing & Duplicating Service	2,000.00	0.00	0.00	2,000.00	0.00
437260	Office Furn & Equip Non-Capita	1,000.00	0.00	0.00	1,000.00	0.00
438220	Copier Rental	2,737.00	2,222.88	0.00	514.12	0.00
439100	Dues & Memberships	400.00	0.00	0.00	400.00	0.00
439200	Training & Staff Development	2,000.00	0.00	0.00	2,000.00	0.00
439400	Publications & Subscriptions	500.00	0.00	0.00	500.00	0.00
	Total Materials & Services	**35,480.00**	**2,222.88**	**3,567.34**	**29,689.78**	**10.05**
	Total PROG 05280	**649,423.00**	**2,222.88**	**73,409.03**	**573,791.09**	**11.30**
	Total DEPT 4344	**649,423.00**	**2,222.88**	**73,409.03**	**573,791.09**	**11.30**
	Total FUND 242	**867,520.00**	**2,222.88**	**77,439.02**	**787,858.10**	**8.93**
	Report Total	**867,520.00**	**2,222.88**	**77,439.02**	**787,858.10**	**8.93**

Rev FY 18-19

Clackamas County
Financial Management System
Revenue Comparison Report
Business Unit: CLACK
Budget Period: 2019
As of Accounting Period: 12 - June

Fund: 242 To 242
DeptID: 4341 To 4345
Program: 05280 To 05280

Report ID: GL002Z
Run Date: 8/27/2019
Run Time: 4:58:32 PM

Account		Estimated Revenue	Collections YTD	Balance	PCT Collected
FUND: 242 Social Services Fund					
DEPT: 4341 Community Action Agencies					
PROGRAM: 05280 Veterans Enhancement Grant					
	Grant Revenue				
332244	State Veterans' Office	13,083.00	71,297.63	58,214.63	544.96
	Total Grant Revenue	**13,083.00**	**71,297.63**	**58,214.63**	**544.96**
	Interfund Transfers				
390100	I/F Transfer From Fund 100	211,941.00	211,941.00	0.00	100.00
	Total Interfund Transfers	**211,941.00**	**211,941.00**	**0.00**	**100.00**
	Total PROGRAM 05280	**225,024.00**	**283,238.63**	**58,214.63**	**125.87**
	Total DEPT 4341	**225,024.00**	**283,238.63**	**58,214.63**	**125.87**

Rev FY 18-19

Clackamas County
Financial Management System
Revenue Comparison Report
Business Unit: CLACK
Budget Period: 2019
As of Accounting Period: 12 - June

Fund: 242 To 242
DeptID: 4341 To 4345
Program: 05280 To 05280

Report ID: GL002Z
Run Date: 8/27/2019
Run Time: 4:58:32 PM

Account		Estimated Revenue	Collections YTD	Balance	PCT Collected
FUND: 242 Social Services Fund					
DEPT: 4344 CAA Information & Assistance					
PROGRAM:	05280 Veterans Enhancement Grant				
	Fund Bal End Prior Year				
302003	Restricted Fund Bal at End of	89,000.00	89,000.00	0.00	100.00
	Total Fund Bal End Prior Year	**89,000.00**	**89,000.00**	**0.00**	**100.00**
	Grant Revenue				
332244	State Veterans' Office	272,108.00	142,595.26	-129,512.74	52.40
	Total Grant Revenue	**272,108.00**	**142,595.26**	**-129,512.74**	**52.40**
	Interfund Transfers				
390100	I/F Transfer From Fund 100	286,145.00	286,145.00	0.00	100.00
	Total Interfund Transfers	**286,145.00**	**286,145.00**	**0.00**	**100.00**
Total PROGRAM 05280		**647,253.00**	**517,740.26**	**-129,512.74**	**79.99**
Total DEPT 4344		**647,253.00**	**517,740.26**	**-129,512.74**	**79.99**
Total FUND 242		**872,277.00**	**800,978.89**	**-71,298.11**	**91.83**
Report Total		**872,277.00**	**800,978.89**	**-71,298.11**	**91.83**

Grant Receivable not posted yet

71,297.63

872,276.52

EXP FY 18-19

Clackamas County
Financial Management System
Statement of Encumbrances and Expenditures
Business Unit: CLACK
Budget Period: 2019
As of Accounting Period: 12 - June

Fund: 242 To 242
DeptID: 4341 To 4345
Program: 05280 To 05280

Report ID: GL001Z
Run Date: 8/27/2019
Run Time: 4:44:52 PM

FUND: 242 Social Services Fund
DEPT: 4341 Community Action Agencies

PROGRAM: 05280 Veterans Enhancement Grant

Account		Appropriation	Encumbered	Expenditures	Avail. Balance	PCT Used
	Personal Services					
411100	Regular Full Time Employees	23,332.00	0.00	23,144.92	187.08	99.20
415000	Fringe Benefits	11,819.00	0.00	9,561.56	2,257.44	80.90
415020	Worker Compensation	3,784.00	0.00	3,934.55	(150.55)	103.98
	Total Personal Services	**38,935.00**	**0.00**	**36,641.03**	**2,293.97**	**94.11**
	Materials & Services					
421100	General Office Supplies	0.00	0.00	5.67	(5.67)	0.00
421110	Postage	0.00	0.00	2,281.63	(2,281.63)	0.00
422400	Food	0.00	0.00	272.96	(272.96)	0.00
433110	Mileage Reimbursement	0.00	0.00	14.18	(14.18)	0.00
435180	Casualty Insurance	3,544.00	0.00	3,685.26	(141.26)	103.99
437960	Property Rental Expense	0.00	0.00	435.00	(435.00)	0.00
438110	Office Rental	12,361.00	0.00	12,853.51	(492.51)	103.98
	Total Materials & Services	**15,905.00**	**0.00**	**19,548.21**	**(3,643.21)**	**122.91**
	Cost Allocation Charges					
477200	Division Indirect Costs	108,365.00	0.00	105,399.60	2,965.40	97.26
478101	Finance Allocated Costs	15,796.00	0.00	16,423.88	(627.88)	103.97
478102	Technology Services Alloc Cost	20,515.00	0.00	21,332.60	(817.60)	103.99
478103	Building Maintenance Allocated	10,425.00	0.00	10,840.22	(415.22)	103.98
478104	PGR Allocated Costs	1,298.00	0.00	1,349.59	(51.59)	103.97
478105	Records Management Allocated C	529.00	0.00	550.32	(21.32)	104.03
478106	Purchasing Services Allocated	485.00	0.00	504.38	(19.38)	104.00
478107	County Courier Allocated Cost	255.00	0.00	265.20	(10.20)	104.00
478111	Personnel Administration Alloc	7,226.00	0.00	7,513.64	(287.64)	103.98
478112	County Administration Allocate	2,436.00	0.00	2,532.57	(96.57)	103.96
478117	Mailroom Overhead	845.00	0.00	879.16	(34.16)	104.04
478201	Electric Utility Allocation	1,279.00	0.00	1,330.00	(51.00)	103.99
478202	Natural Gas Utility Allocation	122.00	0.00	127.27	(5.27)	104.32
478203	Water Utility Allocation	444.00	0.00	461.26	(17.26)	103.89
478204	Trash Removal Allocation	164.00	0.00	170.05	(6.05)	103.69
	Total Cost Allocation Charges	**170,184.00**	**0.00**	**169,679.74**	**504.26**	**99.70**
	Total PROG 05280	**225,024.00**	**0.00**	**225,868.98**	**(844.98)**	**100.38**
	Total DEPT 4341	**225,024.00**	**0.00**	**225,868.98**	**(844.98)**	**100.38**

EXP FY 18-19

Clackamas County
Financial Management System

Fund: 242 To 242
DeptID: 4341 To 4345
Program: 05280 To 05280

Statement of Encumbrances and Expenditures
Business Unit: CLACK
Budget Period: 2019
As of Accounting Period: 12 - June

Report ID: GL001Z
Run Date: 8/27/2019
Run Time: 4:44:52 PM

Account		Appropriation	Encumbered	Expenditures	Avail. Balance	PCT Used
FUND: 242 Social Services Fund						
DEPT: 4344 CAA Information & Assistance						
PROGRAM:	05280 Veterans Enhancement Grant					
	Personal Services					
411100	Regular Full Time Employees	302,892.00	0.00	300,644.88	2,247.12	99.26
413000	Temporary Workers	73,000.00	0.00	10,845.28	62,154.72	14.86
414030	Overtime	0.00	0.00	164.47	(164.47)	0.00
415000	Fringe Benefits	218,870.00	0.00	208,922.57	9,947.43	95.46
	Total Personal Services	**594,762.00**	**0.00**	**520,577.20**	**74,184.80**	**87.53**
	Materials & Services					
421100	General Office Supplies	1,500.00	0.00	576.75	923.25	38.45
421110	Postage	1,250.00	0.00	1,023.32	226.68	81.87
421210	Computer Hardware/Software-Non	5,593.00	0.00	12,592.95	(6,999.95)	225.16
424610	Fuel & Vehicle Rental	0.00	0.00	52.57	(52.57)	0.00
431510	Pre-Employment Tests	0.00	0.00	149.00	(149.00)	0.00
432100	Telephone	5,500.00	0.00	6,715.81	(1,215.81)	122.11
432400	Advertising	1,000.00	0.00	0.00	1,000.00	0.00
433100	Travel & Per Diem (NO MILEAGE)	5,500.00	0.00	8,927.10	(3,427.10)	162.31
433110	Mileage Reimbursement	4,500.00	0.00	1,214.56	3,285.44	26.99
434100	Printing & Duplicating Service	2,000.00	0.00	370.76	1,629.24	18.54
437260	Office Furn & Equip Non-Capita	1,000.00	0.00	9,306.37	(8,306.37)	930.64
438220	Copier Rental	2,737.00	370.48	2,222.88	143.64	81.22
439100	Dues & Memberships	400.00	0.00	540.00	(140.00)	135.00
439200	Training & Staff Development	2,000.00	0.00	700.00	1,300.00	35.00
439400	Publications & Subscriptions	500.00	0.00	486.87	13.13	97.37
450001	Program Expense	19,011.00	0.00	3,845.79	15,165.21	20.23
454300	Records Destruction	0.00	0.00	167.08	(167.08)	0.00
	Total Materials & Services	**52,491.00**	**370.48**	**48,891.81**	**3,228.71**	**93.14**
	Total PROG 05280	**647,253.00**	**370.48**	**569,469.01**	**77,413.51**	**87.98**
	Total DEPT 4344	**647,253.00**	**370.48**	**569,469.01**	**77,413.51**	**87.98**
	Total FUND 242	**872,277.00**	**370.48**	**795,337.99**	**76,568.53**	**91.18**
Report Total		**872,277.00**	**370.48**	**795,337.99**	**76,568.53**	**91.18**

Health, Housing & Human Services
CLACKAMAS COUNTY

Brenda Durbin, *Director*
Social Services Division

August 28, 2019

Oregon Department of Veterans' Affairs
Statewide Veteran Services
700 Summer St NE Salem, OR 97301-1285

Re: Carryover Explanation and Plan

Clackamas County has a $76,938 carry over of County Funds from the 17-18 fiscal year. This was caused when we knew we were going to be getting an increase in funding from ODVA and planned to hire a fourth Veteran Service Officer. It turned out that an internal candidate was selected, but this Navy Veteran was already a case manager for highly vulnerable homeless veterans with serious mental illness. Therefore, in order not to destabilize the veterans already being served, the move to CVSO did not occur until the case management position was refilled. These two hiring processes occurred back to back and were as streamlined as possible but still resulted in the underspending.

Two veterans have been hired on a temporary basis for specific projects which will expend these carry over funds. One veteran is scanning in relevant documents from old paper files to the VetraSpec online database, as well as old paper copies of DD-214s and death certificates that the VSO has been retaining for many years in case veterans or their survivors need them. The second veteran is assisting with outreach to homeless veterans throughout the county, as well as homelessness prevention and housing problem solving for veterans at imminent risk of homelessness.

Please contact me if there are any questions about this carry over explanation and plan.

Respectfully,

Erika Silver
Human Services Manager
(503) 650-5725
esilver@clackamas.us

CLACKAMAS COUNTY

DAN JOHNSON
DIRECTOR

DEPARTMENT OF TRANSPORTATION AND DEVELOPMENT
DEVELOPMENT SERVICES BUILDING
150 BEAVERCREEK ROAD OREGON CITY, OR 97045

September 5, 2019

Board of Commissioners
Clackamas County
Members of the Board:

A Board Order Accepting and Acknowledging Right of Way and Simultaneously Vacating Schmidt Road

Purpose/Outcomes	Acceptance and Acknowledges a permanent right of way easement for road purposes as part of the County Road system. Simultaneously vacates a portion of Schmidt Road right of way.
Dollar Amount and Fiscal Impact	None
Funding Source	N/A
Duration	Upon execution; permanent right of way easement and vacation.
Previous Board Action	N/A
Counsel Review	Reviewed and approved by County Counsel on 08/27/19
Strategic Plan Alignment	Grow a Vibrant Economy
Contact Person	Doug Cutshall, Engineering Technician 503-742-4669

BACKGROUND:
Schmidt Road, (County Road No. 1840), located in the NE quarter of Section12, Township 4 South, Range 2 East, W.M., was dedicated to the public in a deed from George, Kata and, Kilian Schmidt, November 4, 1938. Unfortunately, it appears the location of the existing road was not surveyed and the road as constructed is located entirely out of the right of way. The Schmidt's are partitioning a portion of their property and would very much like to place the road within an accurately described right of way.

The Schmidt's have again offered to the public a 30 foot wide Permanent Right of Way Easement for Road Purposes through their property. Accepting the easement and acknowledging it to be part of the County Road system will allow for the simultaneous vacation of the unused right of way. There are no negative impacts to the traveling public or the adjoining property owners by this road vacation. This action is pursuant to ORS 368.126.

Schmidt Road, lying within the Schmidt property, is open to the public for travel. After considering traffic impacts, fiscal impacts, and social impacts, staff believes that it would be in the public's interest to approve the Board Order accepting the Permanent Right of Way Easement for Road Purposes as part of the County Road system and simultaneously vacate the unused S. Schmidt Road right of way, in accordance with ORS 368.126.

RECOMMENDATION:
Staff respectfully recommends that the Board adopt the attached Board Order accepting the permanent right of way easement for road purposes and acknowledging it as being part of the County Road system and simultaneously vacating the unused S. Schmidt Road right of way, (County Road No. 1840, DTD No. 42009).

Respectfully submitted,

Michael Bays
Survey/ CADD Group Supervisor

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

In the Matter of Accepting and Acknowledging an Easement to be part of the County Road System and the Simultaneous Vacation of a Portion of S Schmidt Road, Co. Rd. No. 1840, DTD No. 42009, Situated in Section 12, T.4 S., R.2 E., W.M.

Board Order No._____

This matter coming before the Board of County Commissioners at this time and it appearing to the Board that the Schmidt Family has offered to the public a Permanent Right of Way Easement for Road Purposes, and;

IT APPEARING to the Board that said easement is being provided to place the constructed county road into an accurately described right of way. Accepting the easement, which is attached to this order and contains descriptions and depictions on the attached Exhibits "A" and "B" and acknowledging said easement to be part of the County Road System, will allow the Board, per ORS 368.126, to simultaneously vacate the unused Schmidt Road right of way; now therefore,

IT IS HEREBY ORDERED that the Board accept the offered Permanent Right of Way Easement for Road Purposes, which is attached to this order,, acknowledge said easement to be a part of the County Road System being County Road Number 1840 and, simultaneously vacate the unused Schmidt Road right of way, as described in Clackamas County Deed Records Book 252, Page 99-100 and, Commission Journal Book 34, Page 489.

IT IS FURTHER ORDERED that this Order and supporting documents be recorded free of charge with the Clackamas County Clerk when presented, with copies sent to the County Assessor Office, County Surveyor's Office, and County Finance/Fixed Assets' Offices.

ADOPTED this _____day of _____, 2019

BOARD OF COUNTY COMMISSIONERS

_____
Chair

_____
Recording Secretary

Grantor: Ralph and Merry Schmidt Address: 24419 Hwy.395 North Kettle Falls, WA 99141 Grantee: Clackamas County 150 Beavercreek Rd. Oregon City, OR 97045 After Recording Return to: Clackamas County Engineering 150 Beavercreek Rd. Oregon City, OR 97045 Until a change is requested, all taxes shall be sent to: No Change Road Name: _____ DTD Rd. File No.	State of Oregon Accepted by Clackamas County by Act of the Road Official Acceptance Date: _____ Authorized by Clackamas County Ordinance No. 02-2009 Project:

PERMANENT RIGHT OF WAY EASEMENT FOR ROAD PURPOSES
(Individual Grantor)

For value received, Ralph Schmidt and Merry Schmidt, (Grantor), hereby grants and conveys to Clackamas County, a political subdivision of the State of Oregon, its heirs, successors and assigns, (Grantee), a permanent easement dedicated to the public for road and right of way purposes, in, under, upon, and across Grantor's real property located in Clackamas County, State of Oregon.

Grantor's real property is more particularly described as follows: A Tract of land located in the NE 1/4 and SE 1/4 of Section 12, T4S, R2E, WM, as described by that certain Statutory Warranty Deed recorded on February 17, 2004, as Document No. 2004-012469 in the Deed Records of Clackamas County, Oregon.

The Permanent Right of Way Easement for Road Purposes is more particularly described as follows: A strip of land as described and depicted in Exhibits "A" and "B" attached hereto and by this reference made a part hereof (the Easement Area).

Grantee's rights include, but are not limited to, Grantee's right to enter upon and utilize the Easement Area for the purposes described in this document. Grantee may remove trees, shrubs, brush, paving or other materials within the Easement Area whenever necessary to accomplish these purposes.

Grantor, Grantor's heirs, successors, assigns or representatives, shall not construct or maintain any building or other structures upon the above described Easement Area.

This easement does not obligate the public or Grantee to replace landscaping, fencing, shrubs or trees that may be placed within the Easement Area, and which interfere with Grantee's use of the Easement Area for the purposes described in this document.

Statutory Land Use Disclaimer: Before signing or accepting this instrument, the person transferring fee title should inquire about the person's rights, if any, under ORS 195.300, 195.301 and 195.305 to 195.336 and Sections 5 to 11, Chapter 424, Oregon Laws 2007, Sections 2 to 9 and 17, Chapter 855, Oregon Laws 2009, and Sections 2 to 7, Chapter 8, Oregon Laws 2010. This instrument does not allow use of the property described in this instrument in violation of applicable land use laws and regulations. Before signing or accepting this instrument, the person acquiring fee title to the property should check with the appropriate city or county planning department to verify that the unit of land being transferred is a lawfully established lot or parcel, as defined in ORS 92.010 or 215.010, to verify the approved uses of the lot or parcel, to determine any limits on lawsuits against farming or forest practices,

195.300, 195.301 and 195.305 to 195.336 and Sections 5 to 11, Chapter 424, Oregon Laws 2007, Sections 2 to 9 and 17, Chapter 855, Oregon Laws 2009, and Sections 2 to 7, Chapter 8, Oregon Laws 2010.

In witness whereof, the above named Grantor has hereunto set Grantor's hand to this document on this 28th day of June 2019.

Signature _____ Ralph Schmidt
Print Name

Signature _____ Merry A. Schmidt
Print Name

STATE OF Washington)
) ss.
County of Ferry)

This instrument was signed and attested before me this 28th day of June 2019,
by Ralph Schmidt and Merry Schmidt.

Linda L Schauls
Notary Public for State of WASHINGTON
My Commission Expires: April 03, 2023

LINDA L SCHAULS
APPOINTMENT EXPIRES
APRIL 09, 2023
NOTARY
PUBLIC
Commission # 207095
STATE OF WASHINGTON

ZTec Engineers, Inc.

Civil ♦ Structural ♦ Surveying

John McL. Middleton, P.E. Chris C. Fischborn, P.L.S. Ronald b. Sellards, P.E.

3880 SE 8th Ave., Suite 280. Portland, Or. 97202 530-235-8795

EXHIBIT "A"

Date: 9-20-18 Schmidt Road

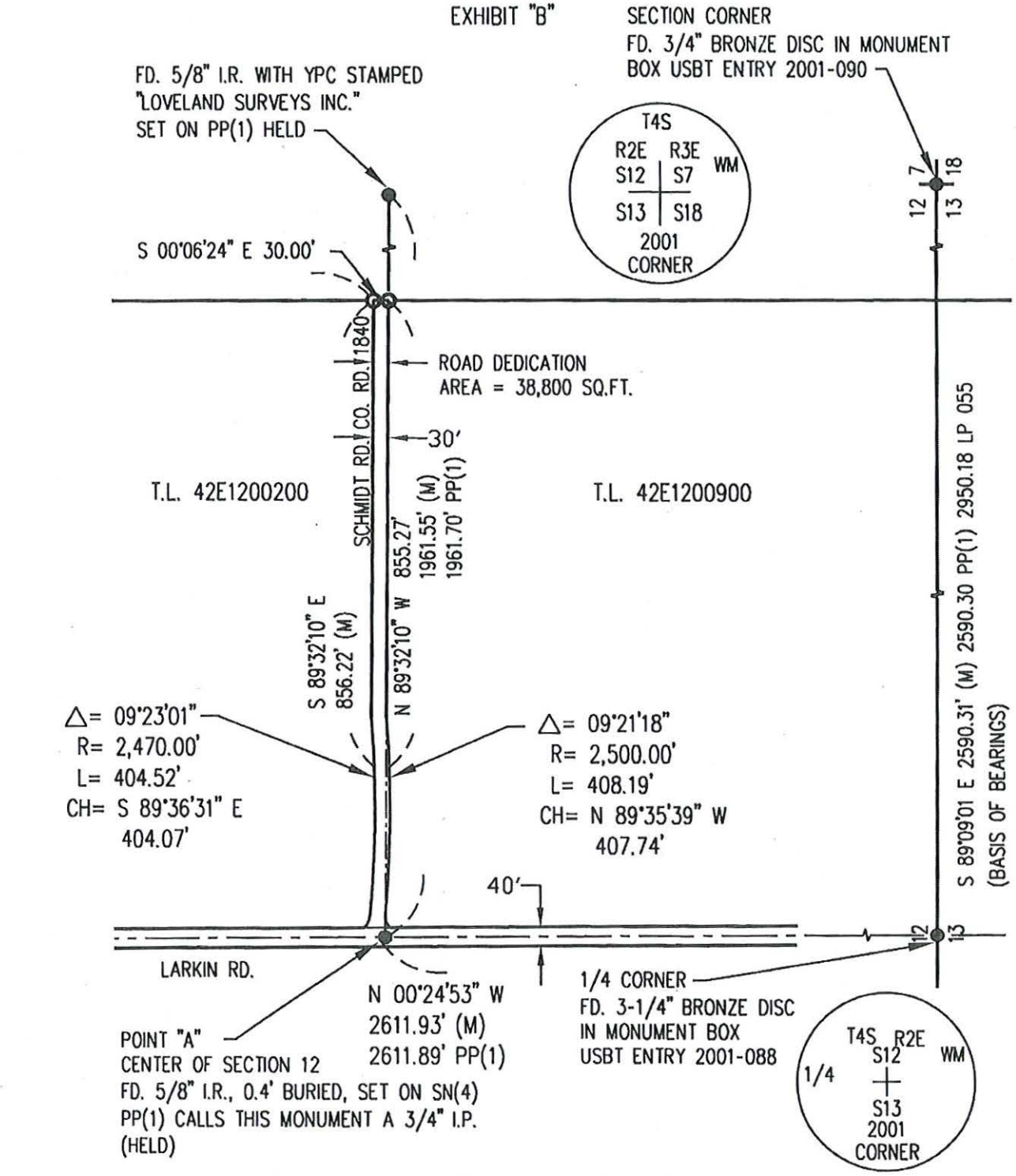
Owner: Ralph and Merry Schmidt Relocation of County Road No. 1840

Tax Lot: 42E12 00200

A Tract of land over and across a portion of the existing Schmidt Road right-of-way as described in that deed recorded November 4, 1939 in Book 252, Page 99, Clackamas County Deed Records, and over and across a portion of Parcel 1 of that tract of land described in that deed recorded as Document No. 2004-012469, Clackamas County Deed Records, all located in the Northeast one-quarter and in the Southeast one-quarter of Section 12, Township 4 South, Range 2 East, of the Willamette Meridian, Clackamas County, Oregon. Said Tract of land being depicted on attached Exhibit "B" and being a part hereof and more particularly described as follows:

Commencing at a 5/8 inch iron rod found at the Center of said Section 12, said iron rod being on the centerline of Larkin Road (County Road No. 385) and being North 00°24'53" West a distance of 2611.93 feet from the South one-quarter corner of said Section 12; thence South 89°32'10" East, along the East-West center of Section line, a distance of 30.00 feet to a point on the East right-of-way line of said Larkin Road and the true point of beginning of the Tract of land herein described; thence North 00°25'05" West, along said East right-of-way line, a distance of 40.28 feet to a point; thence along a 50.00 foot radius non-tangent curve to the left, with a radial bearing of North 39°06'06" East, through a central angle of 34°01'06", an arc distance of 29.69 feet (the long chord of said curve bears South 67°54'27" East a distance of 29.25 feet) to a point of continuing curve; thence along a 2470.00 foot radius curve to the left, through a central angle of 09°23'01", an arc distance of 404.52 feet (the long chord of said curve bears South 89°36'31" East a distance of 404.07 feet) to a point that is 30.00 feet North of, when measured at right angles, said East-West center of Section line; thence South 89°32'10" East, parallel with and 30.00 feet North of, when measured at right angles, said center of Section line, a distance of 856.22 feet to a point on the East line of the West half of the Northeast one-quarter of said Section 12; thence South 00°06'24" East, along said East line, a distance of 30.00 feet to the Southeast corner of said West half of the Northeast one-quarter of said Section 12; thence North 89°32'10" West, along said East-West center of Section line, a distance of 855.27 feet to a point of non-tangent curve; thence along a 2500.00 foot radius curve to the right with a radial bearing of North 04°16'18 West, through a central angle of 09°21'18", an arc distance of 408.19 feet (the long chord of said curve bears North 89°35'39" West a distance of 407.74 feet) to a point of reverse curve; thence along a 27.00 foot radius curve to the left, through a central angle of 58°27'53", an arc distance of 27.55 feet (the long chord of said curve bears South 65°51'03" West a distance of 26.37 feet) to a point on said East right-of-way line of said Larkin Road; thence North 00°24'53" West, along said East right-of-way line, a distance of 11.40 feet to the true point of beginning of the Tract of land herein described.Said Tract of land contains an area of 38,800 square feet more of less.

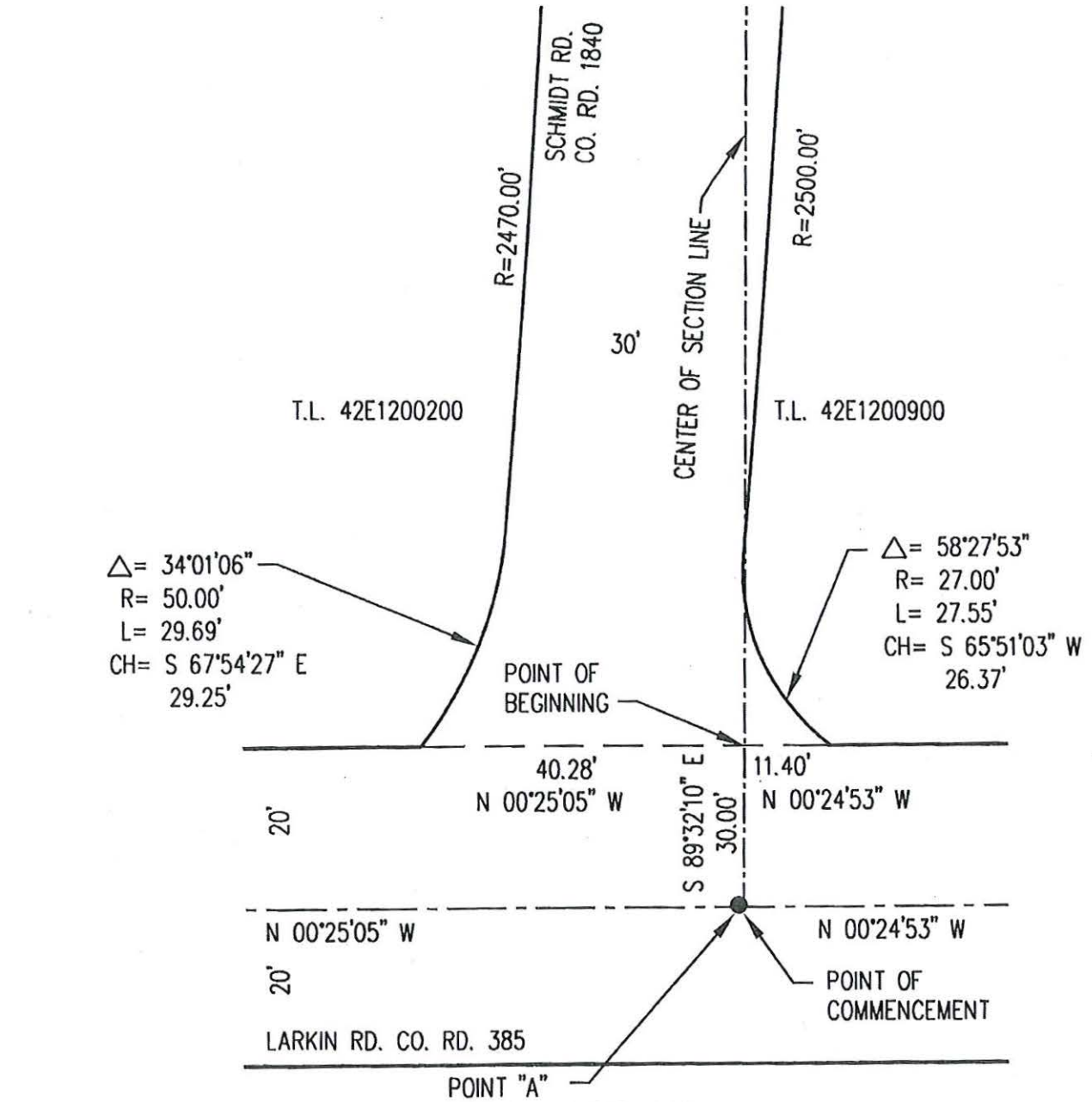
EXHIBIT "B"



PP(1) PARTITION PLAT NO. 2008-082
YPC DENOTES YELLOW PLASTIC CAP
I.R. DENOTES IRON ROD
CO. RD. DENOTES COUNTY ROAD
SN(1) SN 19840

TITLE: RELOCATION OF SCHMIDT RD.	ZTec ENGINEERS, INC.
PLOT DATE: 8-6-18	3880 S.E. 8TH AVE., SUITE 280
FILE: 18-3451-2	PORTLAND, OREGON 97202
CLIENT: RALPH SCHMIDT / SHEET: 1 OF 2	(503) 235-8795

EXHIBIT "B"



SN(1) SN 19840
CO. RD. DENOTES COUNTY ROAD

TITLE: DETAIL OF SCHMIDT RD.	ZTec ENGINEERS, INC.
PLOT DATE: 8-6-18	3880 S.E. 8TH AVE., SUITE 280
FILE: 18-3451-2	PORTLAND, OREGON 97202
CLIENT: RALPH SCHMIDT / SHEET: 2 OF 2	(503) 235-8795

CLACKAMAS COUNTY

DAN JOHNSON
DIRECTOR

DEPARTMENT OF TRANSPORTATION AND DEVELOPMENT
DEVELOPMENT SERVICES BUILDING
150 BEAVERCREEK ROAD OREGON CITY, OR 97045

September 5, 2019

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of a Resolution Declaring the Public Necessity and Purpose for Acquisition of Rights of Way, Easements, and Fee Property for the S Central Point Rd. and S New Era Rd. Intersection Realignment Project and Authorizing Good Faith Negotiations and Condemnation Actions

Purpose/Outcomes	Under ORS 35 and the federal Uniform Act, a local government agency is authorized to declare by resolution or ordinance the necessity and the purpose for which the project is required by enacting a Resolution of Necessity prior to initiating acquisition of the easements or other property rights needed from abutters to the project.
Dollar Amount and Fiscal Impact	The right of way budget for the project is $142,725 and is included within the $1,182,200 total project budget.
Funding Source	County Road Funds/HB 2017 Safety Fund
Duration	The Resolution remains active throughout the project's duration and terminates upon completion of the project or when all litigation associated with the project is concluded.
Previous Board Action	N/A
Strategic Plan Alignment	-Build a strong and safe infrastructure -Ensure safe, healthy and secure communities.
Counsel Review	County Counsel reviewed and approved on 08/27/19
Contact Persons	Sharan Hams-LaDuca, DTD Sr. Right of Way Agent @ 503-742-4675

BACKGROUND:
The intersection of S Central Point Road and S New Era Road is two-way-stop-controlled in the northbound and southbound directions and uncontrolled in the eastbound and westbound directions. It is located south of Oregon City in a rural area. There have been a high number of recorded property and injury accidents at this intersection. There has also been one fatal accident at this intersection. This intersection currently has a 75 degree skew, which may have a correlation with the high percentage of angle crashes. This project will realign the northbound and southbound intersection approaches to reduce the intersection skew. In order to construct the improvements as designed, additional rights of way and easements will be required. The Board has authority to exercise the power of eminent domain under ORS Chapter 35 to acquire rights of way, easements, and fee property by purchase or condemnation proceedings.

The project has been planned and located in a manner which is most compatible with the greatest public good and which causes the least private injury. The design has progressed through the Department of Transportation and Development (DTD) project development procedures and the legal descriptions required for acquisition of the needed rights of way and easements from six properties affected by the Project are being developed.

DTD shall negotiate in good faith and accordance with all applicable laws, rules, and regulations in an attempt to reach agreement as to the amount of Just Compensation owed each affected property owner. To fairly determine the amount of Just Compensation, staff will utilize the expertise of authorized real estate appraisers and other such experts.

The resolution directs DTD staff to proceed with good faith negotiations for the acquisition of the needed property rights and to utilize the expertise of authorized real estate appraisers and other such experts to assist in the acquisition process. The resolution further requires the Director of the Department to notify the Board if the exercise of the power of eminent domain becomes necessary. Only after this process is completed does it authorize the Office of County Counsel to file a Condemnation Action.

RECOMMENDATION:
Staff respectfully recommends that the Board of County Commissioners approve the Resolution of Necessity and Purpose authorizing the acquisition of necessary rights of way, easements, and fee property by good faith negotiation if possible, or condemnation, if necessary for the S Central Point Road and S New Era Road Intersection Realignment Project.

Sincerely,

Sharan Hams-LaDuca
Senior Right of Way Agent

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

In the Matter of the S Central Point Road and S New Era Road Intersection Realignment Project Declaring the Necessity and Purpose for Acquisition of Rights of Way, Easements, and Fee Property, and Authorizing Good Faith Negotiations and Condemnation Actions

Board Order No. _____

This matter comes before the Board of County Commissioners of Clackamas County, Oregon (the "Board") at its regularly scheduled meeting on September 5, 2019 and,

It appearing to the Board that the S Central Point Road and S New Era Road Intersection Realignment Project ("Project") will improve the safety of this intersection by eliminating the 75 degree skew that has contributed to a high number of accidents; is consistent with the powers and purposes of County government; and is necessary for the continued growth, safety and welfare of the community; and,

It further appearing to the Board that the Project has been developed and reviewed by County Staff; and

It further appearing to the Board that the Project has been planned and located in a manner which is most compatible with the greatest public good and causes the least private injury; and,

It further appearing to the Board that rights of way and easements within the boundaries described and depicted in the attached Exhibit "A and B" are a necessary part of the Project; and,

It further appearing to the Board that the acquisition of the necessary rights of way and easements are described as follows: the centerline is described in Exhibit "A and B"; the width of right-of-way will be in accordance with the Clackamas County Comprehensive Plan and Transportation System Plan; ancillary easements including sign, slope, sidewalk, utility, wetland mitigation, storm water treatment, storm water detention, traffic and safety facility, and temporary construction purposes, together with such incidental additional right-of-way at intersections and due to topography, all as may be reasonably necessary to accommodate project design; and any uneconomic remnants, as determined by appraisal; all being in the public interest in order to commence and complete the Project in a timely manner; and,

It further appearing that the Board has authority under ORS Chapter 35 to acquire rights of way, easements, and fee property by good faith negotiation, agreement, and purchase or by exercise of the power of eminent domain with condemnation proceedings.

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

In the Matter of the S Central Point Road and S New Era Road Intersection Realignment Project Declaring the Necessity and Purpose for Acquisition of Rights of Way, Easements, and Fee Property, and Authorizing Good Faith Negotiations and Condemnation Actions

Board Order No. _____

NOW, THEREFORE, IT IS HEREBY RESOLVED that this Board declares it necessary and in the public interest that the County Department of Transportation and Development (Department), in connection with this Project, begin the acquisition process, in accordance with all applicable laws, rules, and regulations governing such process, for the necessary rights of way, easements, and fee property, either through good faith negotiation, agreement, and purchase, or, if necessary, by commencement of condemnation proceedings.

IT IS FURTHER ORDERED THAT:

1) The Department be authorized to, in good faith, attempt to negotiate agreements of just compensation with owners of affected property identified as necessary within the boundaries of Exhibit “A and B”. In so doing, the Department is authorized to retain real estate appraisers, negotiators, and other such experts deemed necessary to assist staff with the acquisition process; and,

2). It is the intention of the Board that the required rights of way, easements, and fee property be obtained through good faith negotiation. The Board acknowledges that the exercise of the power of eminent domain may be necessary. The Director of the Department shall inform the Board when the Director deems eminent domain necessary. Thereafter, the Office of County Counsel is authorized to file complaints of condemnation with the circuit court of the County and take such other steps as it determines necessary for the immediate possession of required rights of way, easements, and fee property and the successful litigation of the condemnation action, including the retention of real estate appraisers, experts and other consultants deemed necessary to the successful conclusion of that litigation.

Dated this _____ day of _____, 2019.

_____
Jim Bernard, Chair

_____
Mary Raethke, Recording Secretary

EXHIBIT "A"

S. Central Point Road
July 23, 2019

CENTERLINE DESCRIPTION OF A PORTION OF S. CENTRAL POINT

A portion of the roadway commonly known as S. Central Point Road, Market Road No. 24, Located in section 24, Township 3 South, Range 1 East, Willamette Meridian, the centerline of which is more particularly described as follows:

Beginning at station 16+00 of the S. Central Point Road alignment, as defined on SN 2019-141 of the Clackamas County Survey records, being 466.12 feet South and 2593.95 feet east of the one-quarter corner common to section 23 and 24, Township 3 South, Range 1 East, Willamette Meridian;

Thence along the centerline of said S. Central Point Road, North 13° 09' 17" East, a distance of 488.61 feet to Station 20+88.61, being the intersection of S. New Era Road, Market Road 570;

Thence North 17° 17' 40" East, a distance of 502.86 feet to a point of curve at Station 25+91.47;

Thence 208.53 feet along a tangent curve to the left, with a delta angle of 06° 15' 21", a radius of 1909.86 feet, and a long chord which bears North 14° 09' 59" East, a distance of 208.42 feet to Station 28+00 of said S. Central Point Road and the Terminus of this centerline description.

Bearings are based on the Oregon Coordinate Reference System, Portland Zone, NAD 83 (2011) epoch 2010.00. Per OAR 734.

REGISTERED
PROFESSIONAL
LAND SURVEYOR

Brian Paull

OREGON
MARCH 13, 2018
BRIAN W. PAULL
89074

EXPIRATION DATE: **12-31-20**

EXHIBIT "B"

S. New Era Road
July 23, 2019

CENTERLINE DESCRIPTION OF A PORTION OF S. NEW ERA ROAD

A portion of the roadway commonly known as New Era Road, County Road No. 570, Located in section 24, Township 3 South, Range 1 East, Willamette Meridian, the centerline of which is more particularly described as follows:

Beginning at station 23+00 of the S. New Era Road alignment, as defined on SN 2019-141 of the Clackamas County Survey records, being 8.23 feet North and 2300.00 feet East of the one-quarter corner common to section 23 and 24, Township 3 South, Range 1 East, Willamette Meridian;

Thence, along the centerline of said S. New Era Road North 89°47'42" East, 405.16 feet to the intersection of S. Central Point Road, being at station 27+05.16 of said S. New Era Road;

Thence, North 89°47'42" East, 394.84 feet to station 31+00, and the Terminus of this centerline description.

Bearings are based on the Oregon Coordinate Reference System, Portland Zone, NAD 83 (2011) epoch 2010.00. Per OAR 734.

REGISTERED
PROFESSIONAL
LAND SURVEYOR

Brian Paull

OREGON
MARCH 13, 2018
BRIAN W. PAULL
89074

EXPIRATION DATE: **12-31-20**

CLACKAMAS COUNTY

DAN JOHNSON
DIRECTOR

DEPARTMENT OF TRANSPORTATION AND DEVELOPMENT
DEVELOPMENT SERVICES BUILDING
150 BEAVERCREEK ROAD OREGON CITY, OR 97045

September 5, 2019

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of a Federal Lands Access Program Project Memorandum of Agreement with Western Federal Lands Highway Division for the East Salmon River Road Surface Preservation Project

Purpose/Outcomes	The purpose of the agreement is to approve a Project Memorandum of Agreement for the East Salmon River Road Surface Preservation Project.
Dollar Amount and Fiscal Impact	Overall Project Cost Estimate: $493,099 Federal Lands Access Program (FLAP) funds: $200,000 County minimum match (10.27%): up to $22,891 County overmatch: up to $270,208
Funding Source	FLAP Funds and County Road Funds.
Duration	Upon execution through summer of 2020
Previous Board Action	06/28/16: BCC Authorization to Apply for Federal Land Access Program Funding 02/15/18: BCC Authorization of the Federal Lands Access Program Match Agreement 07/11/19: BCC Authorization of Western Federal Lands Highway Division Memorandum of Agreement
Counsel Review	Reviewed and approved by County Counsel
Strategic Plan Alignment	-Build a strong infrastructure
Contact Person	Mike Ward, Civil Engineer 503-742-4688

BACKGROUND:
Clackamas County submitted a grant application to Western Federal Lands Highway Division (WFLHD) to perform a two-inch asphalt overlay along 2.03 miles of East Salmon River Road between Highway 26 and the Mount Hood National Forest Boundary to the south. The grant application's total estimated cost was $444,680 with a federal funding request of $395,422. During the grant review process, WFLHD added a ten percent construction phase contingency raising the grant's overall project cost estimate to $493,099.

WFLHD awarded the project $200,000 in federal funds, requiring a minimum County Match of $22,891 based on a 10.27 percent match. Up to an additional $270,208 in County funds will be required to complete the project as envisioned in the grant application. WFLHD's grant award decision was based on the percentage (40%) of traffic that actually travels to the national forest area. Although the grant award is significantly less than the application's request, the road is in need of an asphalt overlay and leveraging the funds to pay for a portion of the overlay project is prudent.

A Program Match Agreement was approved by the Board in February of 2108 to confirm the Clackamas County's intention to meet our grant award and match requirements. A

Memorandum of Agreement with WFLHD which outlined the roles and responsibilities of both parties was approved by the Board in July of 2019.

This Grant Program Description, Federal Award & Administration Information Agreement identifies that the County is accepting the grant funding from WFLHD as discussed in the Memorandum of Agreement, which is included as an exhibit in this agreement.

RECOMMENDATION:
Staff respectfully recommends that the Board of County Commissioners approve the attached Grant Agreement with WFLHD for the East Salmon River Road Surface Preservation Project as listed in the agreement.

Respectfully submitted,

Mike Ward
Civil Engineer

1. Award No.	2. Effective Date	3. CDFA No.
6905671940023	See Block 17	20.224

4. Awarded To
Clackamas County
150 Beavercreek Road
Oregon City, OR 97045 - 4302
DUNS No.: 0969926560000

5. Sponsoring Office
U.S. Department of Transportation
Federal Highway Administration
Western Federal Lands Highway Division

6. Period of Performance
From Effective date to 12/31/2021

7. Total Amount

Federal Share:	$200,000.00
Recipient Share:	$293,099.00
Total Value	$493,099.00

8. Type of Agreement
Grant

9. Authority
23 U.S.C. Section 204

10. Procurement Request No.
HFLWRA180122PR

11. Funds Obligated
$180,000.00

12. Submit Payment Requests To

13. Payment Office
See “Payment” clause in General Terms and Conditions

14. Accounting and Appropriation Data

1517410526391	531.CN.K200.41	1741000000	41012	$180,000.00
				$180,000.00

15. Description of Project
OR CLACK 2639(1), East Salmon River Road Surface Preservation

16. Clackamas County

Signature **Date**
Name: Jim Benard
Title: Commissioner

17. Federal Highway Administration

Signature **Date**
Name: Angy Liljedahl
Title: Agreement Officer

TABLE OF CONTENTS

SECTION A - PROGRAM DESCRIPTION

1. STATEMENT OF PURPOSE

See Section A of the attached Project MOA.

2. LEGISLATIVE AUTHORITY

23 U.S.C. Section 204.

3. PROJECT BACKGROUND AND SCOPE

See Section E of the attached Project MOA.

4. STATEMENT OF WORK

This agreement provides for funding of the construction of the project. An environmental decision document must completed and approved by Federal Highway Administration - WFL Federal Lands Highway Division (FHWA). If FHWA's environmental decision document indicates significant impacts or identifies the preferred alternative to be a "no-build" alternative, then this agreement will be terminated with no eligibility for funding post environmental decision activities. Construction will not be eligible for reimbursement until the Final PS&E package is approved.

FHWA and the Clackamas County (Recipient) may amend or terminate this agreement to adjust to project development, environmental, or construction needs.

A. Preliminary Design

1. Design

1.1. Perform a site survey as necessary to support the design and environmental compliance needs of the project.

1.2. Prepare and submit a preliminary plan package to FHWA. The preliminary plan package shall reflect the work as described in the Project Description above. Any deviations from the described work must be approved in writing by FHWA. Include a preliminary cost estimate with the preliminary plan package.

2. Environmental Compliance

Note: Federally funded projects must fully comply with all requirements of the National Environmental Policy Act (NEPA). An appropriate range of reasonable alternatives will be evaluated for this project based on its scope and extent.

Amendments to the scope of this may be required upon completion of the environmental clearance document and decision.

2.1. Coordinate environmental compliance efforts with FHWA environmental staff. Utilizing the information provided through work performed under this agreement, FHWA will write an independent environmental decision document.

2.2. Support FHWA in environmental compliance efforts, coordinate, develop and complete tasks including resource surveys, studies and assessments for documentation

2.2.1. National Historic Preservation Act (NHPA)

2.2.1.a. FHWA will take the federal lead for Section 106 of the National Historic Preservation Act (NHPA) compliance and perform tribal consultation.

2.2.1.b. Recipient through a qualified archeologist shall perform resource surveys of the area of potential effect (APE) for the project area in compliance with Department of Interior guidelines. If the APE includes land owned or controlled by the federal government, then obtain a permit from the federal land management agency to conduct resource surveys in accordance with the Archaeological Resources Protection Act. Prepare and submit to FHWA a report documenting Section 106 findings and recommendations that complies with applicable State Historic Preservation Office (SHPO) standards for use in Section 106 consultation.

2.2.1.c. FHWA will complete consultation with the SHPO under Section 106 of the NHPA.

2.2.2. Wetlands

2.2.2.a. Recipient through a qualified wetland biologist to identify the presence or absence of wetlands or other waters of the U.S. within the project area. Wetlands believed to be under the jurisdiction of the U.S. Army Corps of Engineers (USACE) should be identified. This may include but is not limited to referencing the National Wetland Inventory or local wetland inventory, NRCS soil survey maps, and field observations.

2.2.2.b. If no potential wetlands are observed within the project area, these findings can be documented in a short report submitted to FHWA.

2.2.2.c. If potential wetlands exist in the project area, delineate and document wetlands in accordance with the USACE 1987 Wetland Delineation Manual and submit the information to FHWA.

2.2.3. Threatened & Endangered (T&E) Species and Essential Fish Habitat (EFH)

2.2.3.a Recipient through a qualified biologist or botanist to perform threatened and endangered species and essential fish habitat studies within the project area. The biologist will obtain updated T&E species lists for the project area from the US Fish and Wildlife Service (USFWS) and, if appropriate, NOAA Fisheries Service.

2.2.3.b If there are no T&E species or EFH within the project area or the proposed project would have no effect to any T&E species or no adverse effect on EFH within the project area, the biologists/botanist shall prepare and submit to FHWA a written finding documenting the finding and the basis for their conclusion.

2.2.3.c If there are T&E species within the project area and the project may affect these species, prepare and submit to FHWA a Biological Assessment (BA) following USFWS and/or NOAA guidelines.

2.2.3.d If the project may affect threatened or endangered species, FHWA will perform Section 7 consultation as appropriate with USFWS and NOAA Fisheries Service. If appropriate, include consultation for EFH.

2.2.4. Other Environmental Issues

2.2.4.a FHWA will identify other environmental issues such as consistency with the Coastal Zone Management Act, floodplains, and hazardous materials

2.2.4.b Submit other environmental surveys, studies, and assessments as needed to support environmental compliance to FHWA.

B. Final Design

1. Design

1.1. Do not initiate final design activities until FHWA has issued an independent environmental decision document(s).

1.2. If the NEPA decision is to construct a project, prepare and submit final plans, specifications, and construction estimate package. The final design package shall reflect the work as described in the environmental decision document. Any deviations from the described work must be approved in writing by FHWA.

2. ROW Acquisition

2.1 Rights-of-way and/or easements acquisitions are not anticipated for this project. Include in the administrative record, a certification that all work will occur within the existing right-of-way.

3. Utility Relocation

3.1. Utility relocation is not anticipated for this project.

4. Permits

4.1 The agency overseeing the construction will identify all permits necessary for construction and submit a list of permits to FHWA.

4.2 Submit copies of all completed applications for necessary permits to FHWA.

4.3 Obtain permits necessary for construction. Submit copies of approved permits with the final design plans, specifications, and estimate package.

C. Advertisement

5.1. Do not initiate construction advertisement activities until FHWA has written an independent environmental decision document.

5.2. Provide notification to FHWA once the contract has been awarded.

D. Construction

1. Do not initiate construction activities until FHWA has written an independent environmental decision document.

2. Construct and administer the project in conformance with the FHWA environmental decision document.

3. Submit before, during, and post construction photographs to FHWA to document project progress.

4. Submit a copy of the final construction acceptance letter.

5. DELIVERABLES

Task	Reference Paragraph	Delivery Due On or Before Date
A. 4. A. PRELIMINARY DESIGN		
1. DESIGN		
• Submit a copy of the preliminary plan package and preliminary cost estimate	A.4.A.1.2	August 2019
2. ENVIRONMENTAL COMPLIANCE		
• Submit a cultural resources report for FHWA review.	A.4.A.2.2.1.b	December 2019
• Submit a report identifying the presence or absence of jurisdictional wetlands	A.4.A.2.2.2.b A.4.A.2.2.2.c	December 2019
• Submit a report documenting T&E and EFH species findings to FHWA.	A.4.A.2.2.3.b A.4.A.2.2.3.c	December 2019
• Submit other environmental surveys, studies, and assessments as needed to support environmental compliance to FHWA.	A.4.A.2.2.4.b	December 2019
A. 4. B. Final Design		
1. DESIGN		
• Submit final plans, specifications, and construction estimate.	A.4.B.1.2	June 2020
2. ROW ACQUISITION		
• Submit certification of rights-of-way and/or easements to FHWA *-or- include certification that all work will occur within existing right-of-way as part of the administrative record.*	A.4.B.2.2	With Final PS&E
3. UTILITY RELOCATION		
• Submit certification of Utility Relocation	A.4.B.3.2	With Final PS&E
4. PERMITS		
• Submit a list of all permits necessary for construction to FHWA	A.4.B.4.1	With Preliminary Plan Package
• Submit copies of all completed applications for necessary permits to FHWA.	A.4.B.4.2	With Final PS&E
• Submit copies of approved permits.	A.4.B.4.3	With Final PS&E
5. ADVERTISEMENT		
• Submit Notice of Contract Award to FHWA	A.4.B.5.3	Upon Award
A. 4. C. CONSTRUCTION		
• Submit before, during, and post construction photographs to FHWA	A.4.C.3	Ongoing
• Submit copy of the Final Construction Acceptance Letter	A.4.C.4	Upon Completion of Construction / December 2020

Note:

- The Recipient will submit a progress report with each request for reimbursement indicating dates covered, work that has been completed within the request for reimbursement coverage dates, and anticipated dates of major project milestones (i.e. survey completion, preliminary design completion, construction start, and construction completion).

- Submit electronic pdf files and one hard copy of all deliverables to FHWA.

6. KEY OFFICIALS

Government – FHWA/Federal Lands Highway Division

Contact: Neal Christensen, Agreement Officer's Representative (AOR)
Voice: (360) 619-7780
Email: Neal.Christensen@dot.gov

Financial Contact:
Contact: Genise Dance
Voice: (360) 619-7534
Email: WFL.Finance@dot.gov

Recipient- Clackamas County, OR

Program Contact:
Name: Joel Howie
Address: 150 Beavercreek Road
Oregon City, OR 97045
Telephone: 503-742-4658
Email: jhowie@clackamas.us

Finance Contact:
Name: Michael Morasko
Address: 150 Beavercreek Road
Oregon City, OR 97045
Telephone: 503-742-5435
Email: mmorasko@clackamas.us

Cooperative Agreement Contact:
Name: Ryan Rice
Address: 150 Beavercreek Road
Oregon City, OR 97045
Telephone: 503-742-5446
Email: rrice@clackamas.us

SECTION B – FEDERAL AWARD INFORMATION

1. TYPE OF AWARD

The planned award type is a Grant.

2. COST SHARING OR MATCHING

See Section K of the attached Project MOA.

3. PERIOD OF PERFORMANCE

The period of performance for this Agreement is in accordance with Block 6 on page one of the Agreement.

4. DEGREE OF FEDERAL INVOLVEMENT

The FHWA does not anticipate substantial Federal involvement between it and the Recipient during the course of this project. The anticipated Federal involvement is included in Sections G, H, and P of the attached Project MOA.

SECTION C - FEDERAL AWARD ADMINISTRATION INFORMATION

1. FEDERAL AWARD NOTICES

Only the AO can commit the FHWA. The award document, signed by the AO, is the authorizing document. Only the AO can bind the Federal Government to the expenditure of funds.

2. ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS

General terms, conditions, and governing regulations that apply to this agreement are available online at:
https://www.fhwa.dot.gov/cfo/contractor_recip/gtandc_generaltermsconditions.cfm

The online list dated March 6, 2015 of “GENERAL TERMS AND CONDITIONS FOR ASSISTANCE AWARDS” shall apply to the resulting award.

A. INDIRECT COSTS

Indirect costs are allowable under this Agreement in accordance with the Recipient’s ---Federally Negotiated Indirect Cost Rates as documented in writing and approved by the Recipient’s cognizant Government agency.

This Indirect Cost provision does not operate to waive the limitations on Federal funding provided in this document. The Recipient’s audited final indirect costs are allowable only insofar as they do not cause the Recipient to exceed the total obligated funding.

B. DATA RIGHTS

The Recipient must make available to the FHWA copies of all work developed in performance with this Agreement, including but not limited to software and data. Data rights under this agreement shall be in accordance with 2 CFR 200.315, Intangible property.

C. PERSONALLY IDENTIFIABLE INFORMATION (PII)

Personally Identifiable Information (PII) as defined at CFR Part 200.79 and 2 CFR 200.82 at will not be requested unless necessary and only with prior written approval of the AO with concurrence from the AOR.

D. AVAILABLE FUNDING

The cost of the work to be reimbursed by FHWA is Not to Exceed the amount in block 11 of the cover page, unless an amendment to the Agreement is made in writing and agreed to by both parties.

E. KEY PERSONNEL

Pursuant to 2 CFR 200.308(c)(2), the Recipient must request prior written approval from the AO for any change in Key Personnel specified in the award. The following person(s) are/have been identified as Key Personnel:

Name	Title/Position
None	

F. SUBAWARDS AND SUBCONTRACTS APPROVAL

The Recipient has been determined to have a procurement system that is approved and accepted by the Government, so are exempt from the requirements of 2 CFR §200.330.

G. ORDER OF PRECEDENCE

The Project MOA is accepted, approved, and incorporated herein as Attachment 1. In the event of any conflict between this agreement document and Project MOA, this Agreement document shall prevail.

H. DESIGNATION AS RESEARCH OR NON-RESEARCH AGREEMENT

This agreement is designated as: NON-RESEARCH

I. CONFERENCE SUPPORT RESTRICTIONS

The Recipient must obtain written approval from the AOR prior to incurring any costs for conference support. See the definition of conference as contained in 2 CFR 200.432.

Food and beverage costs are not allowable conference expenses for reimbursement under this Agreement.

Note: Costs of meals are allowable as a travel per diem expense for individuals on travel status and pursuant to the Travel clause of this Agreement.

J. DISPUTES

The parties to this Agreement will communicate with one another in good faith and in a timely and cooperative manner when raising issues under this provision. Any dispute, which for the purposes of this provision includes any disagreement or claim, between the FHWA and the Recipient concerning questions of fact or law arising from or in connection with this Agreement and whether or not involving alleged breach of this Agreement, may be raised only under this Disputes provision.

Whenever a dispute arises, the parties will attempt to resolve the issues involved by discussion and mutual agreement as soon as practical. In no event will a dispute which arose more than three months prior to the notification made under the following paragraph of this provision constitute the basis for relief under this article unless FHWA waives this requirement.

Failing resolution by mutual agreement, the aggrieved party will document the dispute by notifying the other party in writing of the relevant facts, identify unresolved issues and specify the clarification or remedy sought. Within five working days after providing written notice to the other party, the aggrieved party may, in writing, request a decision from the AO. The AO will conduct a review of the matters in dispute and render a decision in writing within thirty calendar days of receipt of such written request. Any decision of the AO is final and binding unless a party will, within thirty calendar days, request further review as provided below.

Upon written request to one level above the AO or designee, made within thirty calendar days after the AO’s written decision or upon unavailability of a decision within the stated time frame under the preceding paragraph, the dispute will be further reviewed. This review will be conducted by one level above the AO. Following the review, all parties will be notified in writing. Such resolution is not subject to further administrative review and to the extent permitted by law, will be final and binding. Nothing in this Agreement is intended to prevent the parties from pursuing disputes in a United States Federal Court of competent jurisdiction.

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CLACKAMAS COUNTY

DAN JOHNSON
DIRECTOR

DEPARTMENT OF TRANSPORTATION AND DEVELOPMENT
DEVELOPMENT SERVICES BUILDING
150 BEAVERCREEK ROAD OREGON CITY, OR 97045

July 11, 2019

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of a Federal Lands Access Program Project Memorandum of Agreement with Western Federal Lands Highway Division for the East Salmon River Road Surface Preservation Project

Purpose/Outcomes	The purpose of the agreement is to approve a Project Memorandum of Agreement for the East Salmon River Road Surface Preservation Project.
Dollar Amount and Fiscal Impact	Overall Project Cost Estimate: $493,099 Federal Lands Access Program (FLAP) funds: $200,000 County minimum match (10.27%): up to $22,891 County overmatch: up to $270,208
Funding Source	FLAP Funds and County Road Funds.
Duration	Upon execution through summer of 2020
Previous Board Action	06/28/16: BCC Authorization to Apply for Federal Land Access Program Funding 02/15/18: BCC Authorization of the Federal Lands Access Program Match Agreement
Counsel Review	The agreement was reviewed by County Counsel on July 2, 2019
Strategic Plan Alignment	• Build a strong infrastructure
Contact Person	Joel Howie, Civil Engineering Supervisor 503-742-4658

BACKGROUND:
Clackamas County submitted a grant application to Western Federal Lands Highway Division (WFLHD) to perform a two-inch asphalt overlay along 2.03 miles of East Salmon River Road between Highway 26 and the Mount Hood National Forest Boundary to the south. The grant application's total estimated cost was $434,055 with a federal funding request of $394,680. During the grant review process, WFLHD added a ten percent construction phase contingency raising the grant's overall project cost estimate to $493,099.

WFLHD awarded the project $200,000 in federal funds, requiring a minimum County Match of $22,891 based on a 10.27 percent match. Up to an additional $270,208 in County funds will be required to complete the project as envisioned in the grant application. WFLHD's grant award decision was based on the percentage (40%) of traffic that actually travels to the national forest area. Although the grant award is significantly less than the application's request, the road is in need of an asphalt overlay and leveraging the funds to pay for a portion of the overlay project is prudent.

A Program Match Agreement was approved by the Board in February of 2108 to confirm the Clackamas County's intention to meet our grant award and match requirements. This

agreement is required to identify the responsibilities between WFLHD and Clackamas County for the project.

RECOMMENDATION:
Staff respectfully recommends that the Board of County Commissioners approve the attached Project Memorandum of Agreement with WFLHD for the East Salmon River Road Surface Preservation Project as listed in the agreement.

Respectfully submitted,

Joel Howie

Joel Howie
Civil Engineering Supervisor

Federal Lands Access Program
Project Memorandum of Agreement

Project / Facility Name: OR CLACK 2639(1)

Project Route: East Salmon River Road Surface Preservation

State: Oregon

County: Clackamas County

Owner of Federal Lands to which the Project Provides Access: United States Forest Service – Mt. Hood National Forest

Entity with Title or Maintenance Responsibility for Facility: Clackamas County

Type of Work:

- Preliminary Engineering
- NEPA / Permitting
- Rehabilitation
- Construction Engineering / Contract Administration

This Agreement does not obligate (commit to) the expenditure of Federal funds nor does it commit the parties to complete the project. Rather, this agreement sets forth the respective responsibilities as the project proceeds through the project development process.

Parties to this Agreement: Federal Highway Administration, Western Federal Lands Highway Division and Clackamas County

The Program Decision Committee approved this project on August 30, 2016.

AGREED:

Commissioner, Clackamas County — Date: 7-11-19 B.2

Chief of Business Operations, FHWA - WFLHD — Date: 7.23.19

A. PURPOSE OF THIS AGREEMENT:

This Agreement documents the intent of the parties and sets forth the anticipated responsibilities of each party in the development, construction, and future maintenance of the subject project. The purpose of the Agreement is to identify and assign responsibilities for the environmental analysis, design, right-of-way, utilities, acquisition and construction as appropriate for this project, and to insure maintenance of the facility for public use if improvements are made. The parties understand that any final decision as to design or construction will not be made until after the environmental analysis required under the National Environmental Policy Act (NEPA) is completed (this does not prevent the parties from assigning proposed design criteria to be studied in the NEPA process.) Any decision to proceed with the design and construction of the project will depend on the availability of appropriations at the time of obligation and other factors such as issues raised during the NEPA process, a natural disaster that changes the need for the project, a change in Congressional direction, or other relevant factors.

If Federal Lands Access Program (FLAP) funds are used for the development or construction of this project, Clackamas County agrees to provide a matching share equal to 10.27% of the total cost of the project, as detailed more fully in Section J below. When agencies other than Federal Highway Administration – Western Federal Lands Highway Division will be expanding FLAP Funds, the parties agree to execute a separate obligating document. No reimbursement will be made for expenses incurred prior to execution of the obligating document.

B. AUTHORITY:

This Agreement is entered into between the signatory parties pursuant to the provisions of 23 U.S.C. 204.

C. JURISDICTION AND MAINTENANCE COMMITMENT:

The Clackamas County has jurisdictional authority to operate and maintain the existing facility and will operate and maintain the completed project at its expense.

D. FEDERAL LAND MANAGEMENT AGENCY COORDINATION:

Clackamas County has coordinated project development with the USFS – Mt. Hood National Forest. The USFS – Mt. Hood National Forest support of the project is documented by their endorsement of the project application OR FY16-05.

Each party to this agreement who has a primary role in NEPA, design or construction should coordinate their activities with the Federal Highway Administration – Western Federal Lands Highway Division.

E. PROJECT BACKGROUND / SCOPE:

East Salmon River Road is a rural major collector that provides primary access to the Salmon Huckleberry Wilderness. The wilderness is a high quality destination for those who fish for chinook, Coho and steelhead salmon, for hikers and for those who enjoy wilderness camping. Additionally cyclists enjoy using the road It specifically provides access to the BLM lands and the Coquille Tribal Lands.

The project will include guardrail replacement that meets the current AASHTO Standards. The guardrail will be replaced between MP 25.44 and MP 28.50. Approximately 1400 linear feet of guardrail will be replaced.

F. PROJECT BUDGET:

This is the anticipated budget for the project based on information developed to date. Federal Lands Access Program funds in conjunction with matching funds provided by Clackamas County will fund this project as detailed in Section K.

Phase	FLAP Funds			Partner Match		Total
	To FHWA	To CC	Total	From CC	Total	
PE	$10,000	$0	$10,000	$0	$0	$10,000
CE	$10,000	$0	$10,000	$0	$0	$10,000
CN	$0	$180,000	$180,000	$22,891	$22,891	$202,891
	$20,000	$180,000	$200,000	$22,891	$22,891	$222,891

Note: The total match is calculated on the total FLAP funds provided. However, the total project cost is $493,099. The FLAP amount is limited to $200,000.

G. ROLES AND RESPONIBILITIES:

Clackamas County will provide full support in the NEPA and environmental review process. This includes, but is not limited to: obtaining permits, providing documentation to support NEPA, Endangered Species Act (ESA), and Section 106 compliance, performing studies, etc. FHWA will be responsible for making the NEPA decision.

Clackamas County will administer the other phases of project development such as survey, geotechnical investigation (if required), hydraulic investigation (if required) right-of-way plan preparation (if required), preliminary and final design. The project will be designed to AASHTO Standards. Clackamas County will obtain, or will require the contractor to obtain, all necessary Federal, State, or local permits.

Clackamas County will be responsible for the acquisition of any rights-of-way, easements and / or permits necessary to complete the project. Clackamas County will not initiate right-of-way acquisition until FHWA has written an environmental decision document.

Although not expected, prior to Clackamas County soliciting bids for the project, Clackamas County will certify to FHWA that all right-of-way appraisals and acquisitions have been performed in accordance with the Uniform Relocation Assistance and Real Properties Acquisition Policies Act of 1970 and the Uniform Relocation Act Amendments of 1987.

Although not expected, Clackamas County will be responsible for the relocation of any utilities necessary to complete the project. In accordance with 23 CFR PART 645.103; any applicable reimbursement to the utility company will be governed by State and federal Laws and regulations, or Occupancy Permits. Utility relocation costs will be reimbursable under the construction costs for the project.

During the construction phase, Clackamas County will appoint a Project Engineer to oversee and inspect the work to ensure a quality product. The construction will be governed by the Oregon Standard Specifications for Construction, 2015 Edition.

Clackamas County will be responsible for the following:

- Appointing a representative who will be the primary contact for FHWA's Project Manager.

- Project activities identified in Section P.
- Provide appropriate match to all FLAP funds expended on the project even if the project is terminated prior to completion.
- Upon completion of construction, provide copies of final inspection demonstrating the project has been constructed in substantial conformity with the approved plans and specifications.
- Provide written confirmation of its final acceptance of the constructed project.
- Compliance with terms and conditions as noted in 2 CFR 200 Common Rule Requires.

FHWA will be responsible for the following:

- Stewardship and oversight activities identified in Section P.
- FHWA decisions that may not be delegated, identified in Section P.

H. ROLES AND RESPONSIBILITIES – SCHEDULE:

Responsible Lead	Product/Service	Schedule Finish
Clackamas County	30% Design	August 2019
Clackamas County	Environmental Reviews and Studies	December 2019
FHWA	NEPA Decision	February 2020
Clackamas County	Final Design	June 2020
Clackamas County	Construction	Summer 2020

I. PROPOSED DESIGN STANDARDS:

Preferred design alternatives will be determined through the NEPA process. The following design criteria will be applied on the project:

Criteria		Comments
Standard Design	AASHTO	Oregon Standard Drawings
Functional Classification	Major Collector	
Surface Type	Asphalt	
Design Volume	1,400	20 year projection, currently at 1,135 ADT

J. FUNDING:

The project is partially funded by the Federal Lands Access Program administered by FHWA-WFL, with matching funds and additional funds provided by Clackamas County.

Fund Source	Amount	Comments
Title 23 FLAP funds – K200	PE - $10,000 CE - $10,000 CN - $180,000	The PDC agreed to provide $200,000 of funding including $20,000 for S/O and NEPA
Local Matching Share – Clackamas County (10.27%)	$22,891	In-kind services
Additional funds – Clackamas County	$270,208	
TOTAL	$493,099	

K. MATCHING SHARE REQUIREMENTS:

The purpose of this section is to document the intent of Clackamas County to meet its match requirement for the subject project as authorized under Section 23 USC 201(b)(7)(B). All FLAP expenditures associated with this project will need to be matched by a non-Federal sources, other Federal funds other than those made available under Title 23 and 49 of the United States Code, or by funds made available under 23 USC 202 and 203. The matching requirement under the FAST Act will be met by Clackamas County

Clackamas County has committed to the project. The forms of match shall be those consistent with the "Federal-Aid Guidance Non-Federal Matching Requirements" and as approved by FHWA-WFL. In the state of Oregon, 10.27% of the total project cost.

This project is authorized to use a Tapered Match. Under this approach, the non-Federal match is imposed over the entire project rather than individual progress payments. Timing of all fund transfers are specified under the Funding Plan. Tapered Match is authorized because it will result in an earlier completion date.

Estimated cost and fiscal year (FY) for the funding are based on the best budgeting and scheduling information known at the time. The final match will be determined based on actual expenditures at the conclusion of the project work. Matching cash funds in FWHA-WFL receipt may need to be supplemented, or returned, once actual expenditures are determined. As noted under Modifications, if cost increase over the amount within this agreement, FHWA-WFL will consult with the agency providing match before granting approval.

Maintain all project records, including source documentation for all expenditures and in-kind contributions, for a period of three (3) years from the date of final acceptance. If any litigation claim, negotiation, or audit has been started before expiration of the three-year period, the records shall be retained until completion of the action or resolution of all issues that arise from it.

The following agencies have agreed to contribute the amounts showing which will reduce the federal share by the same amount. The funding plan is as follows:

Agency	Phase	Form	Due	Value	Comments
Clackamas County	PE/CN	In-Kind Services	7/1/2020	$22,891	This is to match the FLAP amount, additional funds are needed to complete the project

L. PROJECT TEAM MEMBERS – POINT OF CONTACT:

The following table provides the points of contact for this project. They are to be the first persons to deal with any issues or questions that arise over the implementation of each party's role and responsibility for this agreement.

Name & Title	Agency	Phone & Email
Joel Howie, Civil Engineering Supervisor	Clackamas County	503-742-4658 jhowie@co.clackamas.or.us
Neal Christensen, Program Manager	FHWA	360-619-7780 Neal.christensen@dot.gov

M. CHANGES / AMENDMENTS / ADDENDUMS:

The agreement may be modified, amended, or have addendums added by mutual agreement of all parties. The change, amendment, or addendum must be in writing and executed by all parties.

Potential changes include, but are not limited to, changes that significantly impact scope, schedule, or budget; changes to the local match, either in type or responsibility; change that alter the level of effort or responsibilities of a party. The parties commit to consider suggested changes in good faith. Failure to reach agreement on changes may be cause for termination of this agreement.

A change in composition of the project team members does not require the agreement to be amended.

It is the responsibility of the project team members to recognize when changes are needed and to make timely notifications to their management in order to avoid project delivery delays.

N. ISSUE RESOLUTION PROCEDURES MATRIX:

Issues should be resolved at the lowest level possible. The issue should be clearly defined in writing and understood by all parties. Escalating to the next level can be requested by any party. When an issue is resolved, the decision will be communicated to all levels below.

FHWA	Clackamas County	Time
Neal Christensen Program Manager neal.christensen@dot.gov 360-619-7780	Joel Howie Civil Engineering Supervisor jhowie@co.clackamas.or.us 503-742-4658	15 Days
Pete Field Environment, Planning and Programming Branch Chief Peter.field@dot.gov 360-619-7619	Mike Bezner Assistant Director of Transportation mikebez@clackamas.us 503-742-4651	15 Days
Dan Donovan Chief of Business Operations Daniel.donovan@dot.gov 360-619-7966	Dan Johnson Director of Transportation danjoh@clackamas.us 503-742-4326	15 Days

O. TERMINATION:

This agreement may be terminated by mutual written consent of all parties. This agreement may also be terminated if either the NEPA process or funding availability requires a change and the parties are not able to agree to the change. Any termination of this agreement shall not prejudice any rights or obligations accrued to the parties prior to termination. If Federal access funds have been expended prior to termination, the party responsible for the match agrees to provide a match in the applicable percentage of the total amount expended on the project prior to the termination.

P. STEWARDSHIP & OVERSIGHT ACTIVITIES:

Phase	Activity	Roles		Comments
		Clackamas County	FHWA	
Planning & Programming	Design exception approval agency identified	Provide	Approve	
Planning & Programming	Evidence of funding allocation	Signed Match Agreement	File copy	Completed
Planning & Programming	Memorandum of Agreement with scope, schedule, & budget	Signed MOA	File copy	
Environment	Identify NEPA contact		Provide	FHWA must be a lead agency on NEPA
Environment	Complete all environmental documents necessary for FHWA to develop an environmental decision (ESA, Section 106, 4F, etc.)	Provide	Review and prepare environmental decision	
Environment	NEPA – Tribal coordination		Provide	FHWA must perform this task
Environment	Obtain environmental permits	Provide	File copy	
Environment	Attend public meetings	Notify	Attend as determined by FHWA	
Environment	FHWA NEPA decision	Comply	Provide	FHWA approval needed
Design	Complete 30% PS&E	Provide	Concur	Completed
Design	Complete 95% PS&E	Provide	Approve	Must have written approval by FHWA

Design	Review or approve design exceptions	Provide	Approve	Follow ODOT's process
Acquisitions	Approval of proprietary products	Provide	Approve	
Acquisitions	Contract package for required clauses (Civil Rights, Davis Bacon, Buy America/American, etc.)	Provide	Approve	
Acquisitions	Receive copy of award package	Provide	File copy	
Acquisitions	Review and approve contract modifications	Provide	Approve	
Construction	Attend Pre-Construction Meeting	Attend	Attend as determined by FHWA	
Construction	Final Project Inspections	Attend	Attend as determined by FHWA	
Construction	Construction photographs of project, before, during (quarterly) and post construction	Provide	File	
Construction	Copy of As-Builts	Provide	File	
Construction	Contract disputes (Claims)	Provide	Review and Provide assistance as warranted	
Construction	Copy of Final Construction Acceptance Letter and report	Provide	Review	

Oregon
Kate Brown, Governor

Department of Transportation
Financial Services Branch
355 Capital Street NE MS #21
Salem OR 97301
Phone: (503) 986-3900
Fax: (503) 986-3907

CENTRAL SERVICE ALLOCATION PLAN
July 1, 2019 – June 30, 2020

May 14, 2019

Clackamas County
Attn: Jian Zhang
2051 Kaen Road
Oregon City, OR 97045

As outlined by the Office of Management and Budget (OMB) in 2 CFR Part 200 (formerly OMB Circular A-87 and 2 CFR 225), the Oregon Department of Transportation (ODOT) recommends the Clackamas County Central Service Cost Allocation Rates cited in this agreement for fiscal year ending June 30, 2020.

Since ODOT is not an authorized federal cognizant audit agency, the cost rates below are for use on federal grants and contracts administered by ODOT with the federal government grants and contracts to which 2 CFR Part 200 applies. The rate was negotiated by Clackamas County and ODOT according to the authority contained in Appendix VII, Section D.1b of 2 CFR Part 200. Other entities may use this rate as the costs presented are in accordance with OMB 2 CFR Part 200.

The rate delineated in this section is effective for the period of July 1, 2019 through June 30, 2020. The rate is applicable to all programs exclusive of "pass-through" programs or those exempt by law.

Indirect Costs, Direct Costs and Central Service Allocations were based on actual expenditures for the 2017-2018 fiscal year.

ODOT accepts the submitted indirect cost rates from the county, no adjustments are proposed. Indirect rates shall be applied to direct salary & wages.

Below is list of Clackamas County Division's approved indirect cost rates for ODOT purposes.

Transportation Construction	35.35%
Transportation Maintenance	38.93%
Transportation Safety	40.93%
Long Range Planning	40.67%
Development Agency	43.63%
Land Use, Dev & Permitting, Road Fund	26.70%

The rates in this agreement should be allocated to all Federal grant programs and contracts for the effective period. Costs allocable to programs which restrict reimbursement of indirect costs may not be allocated to other participating programs.

For the Oregon Department of Transportation	*For Clackamas County*
Tracy Wroblewski	
Tracy Wroblewski *Chief Financial Officer*	*Christa Bosserman Wolfe* *Finance Director*
5-17-19	5/17/19
Date	*Date*

CLACKAMAS COUNTY

DAN JOHNSON
DIRECTOR

DEPARTMENT OF TRANSPORTATION AND DEVELOPMENT
DEVELOPMENT SERVICES BUILDING
150 BEAVERCREEK ROAD OREGON CITY, OR 97045

September 5, 2019

Board of County Commissioner
Clackamas County

Members of the Board:

Approval of a Federal Lands Access Program Project Grant Agreement
with Western Federal Lands Highway Division for the
Lolo Pass Road Stabilization and Surface Preservation Project

Purpose/Outcomes	The purpose of the agreement is to approve a Project Grant Agreement for the Lolo Pass Road Stabilization and Surface Preservation Project.
Dollar Amount and Fiscal Impact	Overall Project Cost Estimate: $4,052,403 Federal Lands Access Program (FLAP) funds: $3,241,922 County minimum match (10.27%): up to $371,052 County overmatch: up to $439,429
Funding Source	FLAP Funds and County Road Funds.
Duration	Upon execution through summer of 2021
Previous Board Action	06/28/16: BCC Authorization to Apply for Federal Land Access Program Funding 02/15/18: BCC Authorization of the Federal Lands Access Program Match Agreement 07/11/19: BCC Authorization of Western Federal Lands Highway Division Memorandum of Agreement
Counsel Review	Reviewed and approved by County Counsel
Strategic Plan Alignment	-Build a strong infrastructure
Contact Person	Mike Ward, Civil Engineer 503-742-4688

BACKGROUND:
Clackamas County submitted a grant application to Western Federal Lands Highway Division (WFLHD) to stabilize and improve Lolo Pass Road by extending a section of existing revetment constructed as a part of the Lolo Pass Road Emergency Repair Project. The revetment construction is intended to reduce the likelihood that the Sandy River will leave its banks during the next flood event at this location. Additionally, Lolo Pass Road will receive a two-inch asphalt overlay along the entire 3.99 miles of road between Highway 26 and the Mount Hood National Forest Boundary to the north. The grant application's total estimated cost was $3,696,370 with a federal funding request of $3,316,753. During the grant review process, WFLHD added a ten percent construction phase contingency raising the grant's overall project cost estimate to $4,052,403.

WFLHD awarded the project $3,241,922 in federal funds, requiring a minimum County Match of 10.27 percent or $371,052. Up to an additional $439,429 in County funds will be required to complete the project as envisioned in the grant application. WFLHD's grant award decision was based on providing 80 percent of the project's total estimated cost. Although the grant award is less than the application's request, the revetment adjacent to Lolo Pass road described in the

grant application is in need of stabilization, the entire road limits are in need of an asphalt overlay and leveraging the funds to pay for most of the project is prudent.

A Program Match Agreement was approved by the Board in February of 2018 to confirm the Clackamas County's intention to meet our grant award and match requirements. A Memorandum of Agreement with WFLHD outlined the roles and responsibilities of both parties was approved by the Board in July of 2019.

This Grant Program Description, Federal Award & Administration Information Agreement identifies that the County is accepting the grant funding from WFLHD as discussed in the Memorandum of Agreement, which is included as an exhibit in this agreement.

RECOMMENDATION:
Staff respectfully recommends that the Board of County Commissioners approve the attached Grant Agreement with WFLHD for the Lolo Pass Road Stabilization and Surface Preservation Project as listed in the agreement.

Respectfully submitted,

Mike Ward,
Civil Engineer

1. Award No.	2. Effective Date	3. CDFA No.
6905671940020	See Block 17	20.224

4. Awarded To
Clackamas County
150 Beavercreek Road
Oregon City, OR 97045 - 4302
DUNS No.: 096992656

5. Sponsoring Office
U.S. Department of Transportation
Federal Highway Administration
Western Federal Lands Highway Division

6. Period of Performance
From Effective date to 12/31/2022

7. Total Amount

Federal Share:	$3,241,992.00
Recipient Share:	$ 810,411.00
Total Value	$4,052,403.00

8. Type of Agreement
Grant

9. Authority
23 U.S.C. Section 204

10. Procurement Request No.
HFLWRA180123PR

11. Funds Obligated
$3,221,922.00

12. Submit Payment Requests To **13. Payment Office**
See “Payment” clause in General Terms and Conditions

14. Accounting and Appropriation Data

1517410570052	531.CN.K200.41	1741000000	41012	$3,221,992.00
				$3,221,992.00

15. Description of Project
OR CLACK 37005(2), Lolo Pass Road Stabilization and Surface Preservation

16. Clackamas County

Signature **Date**
Name: Jim Benard
Title: Commissioner

17. Federal Highway Administration

Signature **Date**
Name: Angy Liljedahl
Title: Agreement Officer

TABLE OF CONTENTS

SECTION A - PROGRAM DESCRIPTION

1. STATEMENT OF PURPOSE

See Section A of the attached Project MOA.

2. LEGISLATIVE AUTHORITY

23 U.S.C. Section 204.

3. PROJECT BACKGROUND AND SCOPE

See Section E of the attached Project MOA.

4. STATEMENT OF WORK

This agreement provides for funding of the construction of the project. An environmental decision document must completed and approved by Federal Highway Administration - WFL Federal Lands Highway Division (FHWA). If FHWA's environmental decision document indicates significant impacts or identifies the preferred alternative to be a "no-build" alternative, then this agreement will be terminated with no eligibility for funding post environmental decision activities. Construction will not be eligible for reimbursement until the Final PS&E package is approved.

FHWA and the Clackamas County (Recipient) may amend or terminate this agreement to adjust to project development, environmental, or construction needs.

A. Preliminary Design

1. Design

1.1. Perform a site survey as necessary to support the design and environmental compliance needs of the project.

1.2. Prepare and submit a preliminary plan package to FHWA. The preliminary plan package shall reflect the work as described in the Project Description above. Any deviations from the described work must be approved in writing by FHWA. Include a preliminary cost estimate with the preliminary plan package.

2. Environmental Compliance

Note: Federally funded projects must fully comply with all requirements of the National Environmental Policy Act (NEPA). An appropriate range of reasonable alternatives will be evaluated for this project based on its scope and extent.

Amendments to the scope of this may be required upon completion of the environmental clearance document and decision.

2.1. Coordinate environmental compliance efforts with FHWA environmental staff. Utilizing the information provided through work performed under this agreement, FHWA will write an independent environmental decision document.

2.2. Support FHWA in environmental compliance efforts, coordinate, develop and complete tasks including resource surveys, studies and assessments for documentation

2.2.1. National Historic Preservation Act (NHPA)

2.2.1.a. FHWA will take the federal lead for Section 106 of the National Historic Preservation Act (NHPA) compliance and perform tribal consultation.

2.2.1.b. Recipient through a qualified archeologist shall perform resource surveys of the area of potential effect (APE) for the project area in compliance with Department of Interior guidelines. If the APE includes land owned or controlled by the federal government, then obtain a permit from the federal land management agency to conduct resource surveys in accordance with the Archaeological Resources Protection Act. Prepare and submit to FHWA a report documenting Section 106 findings and recommendations that complies with applicable State Historic Preservation Office (SHPO) standards for use in Section 106 consultation.

2.2.1.c. FHWA will complete consultation with the SHPO under Section 106 of the NHPA.

2.2.2. Wetlands

2.2.2.a. Recipient through a qualified wetland biologist to identify the presence or absence of wetlands or other waters of the U.S. within the project area. Wetlands believed to be under the jurisdiction of the U.S. Army Corps of Engineers (USACE) should be identified. This may include but is not limited to referencing the National Wetland Inventory or local wetland inventory, NRCS soil survey maps, and field observations.

2.2.2.b. If no potential wetlands are observed within the project area, these findings can be documented in a short report submitted to FHWA.

2.2.2.c. If potential wetlands exist in the project area, delineate and document wetlands in accordance with the USACE 1987 Wetland Delineation Manual and submit the information to FHWA.

2.2.3. Threatened & Endangered (T&E) Species and Essential Fish Habitat (EFH)

2.2.3.a Recipient through a qualified biologist or botanist to perform threatened and endangered species and essential fish habitat studies within the project area. The biologist will obtain updated T&E species lists for the project area from the US Fish and Wildlife Service (USFWS) and, if appropriate, NOAA Fisheries Service.

2.2.3.b If there are no T&E species or EFH within the project area or the proposed project would have no effect to any T&E species or no adverse effect on EFH within the project area, the biologists/botanist shall prepare and submit to FHWA a written finding documenting the finding and the basis for their conclusion.

2.2.3.c If there are T&E species within the project area and the project may affect these species, prepare and submit to FHWA a Biological Assessment (BA) following USFWS and/or NOAA guidelines.

2.2.3.d If the project may affect threatened or endangered species, FHWA will perform Section 7 consultation as appropriate with USFWS and NOAA Fisheries Service. If appropriate, include consultation for EFH.

2.2.4. Other Environmental Issues

2.2.4.a FHWA will identify other environmental issues such as consistency with the Coastal Zone Management Act, floodplains, and hazardous materials

2.2.4.b Submit other environmental surveys, studies, and assessments as needed to support environmental compliance to FHWA.

B. Final Design

1. Design

1.1. Do not initiate final design activities until FHWA has issued an independent environmental decision document(s).

1.2. If the NEPA decision is to construct a project, prepare and submit final plans, specifications, and construction estimate package. The final design package shall reflect the work as described in the environmental decision document. Any deviations from the described work must be approved in writing by FHWA.

2. ROW Acquisition

2.1 Rights-of-way and/or easements acquisitions are not anticipated for this project. Include in the administrative record, a certification that all work will occur within the existing right-of-way.

3. Utility Relocation

3.1. Utility relocation is not anticipated for this project.

4. Permits

4.1 The agency overseeing the construction will identify all permits necessary for construction and submit a list of permits to FHWA.

4.2 Submit copies of all completed applications for necessary permits to FHWA.

4.3 Obtain permits necessary for construction. Submit copies of approved permits with the final design plans, specifications, and estimate package.

C. Advertisement

5.1. Do not initiate construction advertisement activities until FHWA has written an independent environmental decision document.

5.2. Provide notification to FHWA once the contract has been awarded.

D. Construction

1. Do not initiate construction activities until FHWA has written an independent environmental decision document.

2. Construct and administer the project in conformance with the FHWA environmental decision document.

3. Submit before, during, and post construction photographs to FHWA to document project progress.

4. Submit a copy of the final construction acceptance letter.

5. DELIVERABLES

Task	Reference Paragraph	Delivery Due On or Before Date
A. 4. A. PRELIMINARY DESIGN		
1. DESIGN		
• Submit a copy of the preliminary plan package and preliminary cost estimate	A.4.A.1.2	August 2019
2. ENVIRONMENTAL COMPLIANCE		
• Submit a cultural resources report for FHWA review.	A.4.A.2.2.1.b	February 2020
• Submit a report identifying the presence or absence of jurisdictional wetlands	A.4.A.2.2.2.b A.4.A.2.2.2.c	February 2020
• Submit a report documenting T&E and EFH species findings to FHWA.	A.4.A.2.2.3.b A.4.A.2.2.3.c	February 2020
• Submit other environmental surveys, studies, and assessments as needed to support environmental compliance to FHWA.	A.4.A.2.2.4.b	February 2020
A. 4. B. Final Design		
1. DESIGN		
• Submit final plans, specifications, and construction estimate.	A.4.B.1.2	December 2020
2. ROW ACQUISITION		
• Submit certification of rights-of-way and/or easements to FHWA *-or- include certification that all work will occur within existing right-of-way as part of the administrative record.*	A.4.B.2.2	With Final PS&E
3. UTILITY RELOCATION		
• Submit certification of Utility Relocation	A.4.B.3.2	With Final PS&E
4. PERMITS		
• Submit a list of all permits necessary for construction to FHWA	A.4.B.4.1	With Preliminary Plan Package
• Submit copies of all completed applications for necessary permits to FHWA.	A.4.B.4.2	With Final PS&E
• Submit copies of approved permits.	A.4.B.4.3	With Final PS&E
5. ADVERTISEMENT		
• Submit Notice of Contract Award to FHWA	A.4.B.5.3	Upon Award
A. 4. C. CONSTRUCTION		
• Submit before, during, and post construction photographs to FHWA	A.4.C.3	Ongoing
• Submit copy of the Final Construction Acceptance Letter	A.4.C.4	Upon Completion of Construction / December 2021

Note:

- The Recipient will submit a progress report with each request for reimbursement indicating dates covered, work that has been completed within the request for reimbursement coverage dates, and anticipated dates of major project milestones (i.e. survey completion, preliminary design completion, construction start, and construction completion).

- Submit electronic pdf files and one hard copy of all deliverables to FHWA.

6. KEY OFFICIALS

Government – FHWA/Federal Lands Highway Division

Contact: Neal Christensen, Agreement Officer's Representative (AOR)
Voice: (360) 619-7780
Email: Neal.Christensen@dot.gov

Financial Contact:
Contact: Genise Dance
Voice: (360) 619-7534
Email: WFL.Finance@dot.gov

Recipient- Clackamas County, OR

Program Contact:
Name: Joel Howie
Address: 150 Beavercreek Road
Oregon City, OR 97045
Telephone: 503-742-4658
Email: jhowie@clackamas.us

Finance Contact:
Name: Michael Morasko
Address: 150 Beavercreek Road
Oregon City, OR 97045
Telephone: 503-742-5435
Email: mmorasko@clackamas.us

Cooperative Agreement Contact:
Name: Ryan Rice
Address: 150 Beavercreek Road
Oregon City, OR 97045
Telephone: 503-742-5446
Email: rrice@clackamas.us

SECTION B – FEDERAL AWARD INFORMATION

1. TYPE OF AWARD

The planned award type is a Grant.

2. COST SHARING OR MATCHING

See Section K of the attached Project MOA.

3. PERIOD OF PERFORMANCE

The period of performance for this Agreement is in accordance with Block 6 on page one of the Agreement.

4. DEGREE OF FEDERAL INVOLVEMENT

The FHWA does not anticipate substantial Federal involvement between it and the Recipient during the course of this project. The anticipated Federal involvement is included in Sections G, H, and P of the attached Project MOA.

SECTION C - FEDERAL AWARD ADMINISTRATION INFORMATION

1. FEDERAL AWARD NOTICES

Only the AO can commit the FHWA. The award document, signed by the AO, is the authorizing document. Only the AO can bind the Federal Government to the expenditure of funds.

2. ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS

General terms, conditions, and governing regulations that apply to this agreement are available online at:
https://www.fhwa.dot.gov/cfo/contractor_recip/gtandc_generaltermsconditions.cfm

The online list dated March 6, 2015 of “GENERAL TERMS AND CONDITIONS FOR ASSISTANCE AWARDS” shall apply to the resulting award.

A. INDIRECT COSTS

Indirect costs are allowable under this Agreement in accordance with the Recipient’s Federally Negotiated Indirect Cost Rates as documented in writing and approved by the Recipient’s cognizant Government agency.

This Indirect Cost provision does not operate to waive the limitations on Federal funding provided in this document. The Recipient’s audited final indirect costs are allowable only insofar as they do not cause the Recipient to exceed the total obligated funding.

B. DATA RIGHTS

The Recipient must make available to the FHWA copies of all work developed in performance with this Agreement, including but not limited to software and data. Data rights under this agreement shall be in accordance with 2 CFR 200.315, Intangible property.

C. PERSONALLY IDENTIFIABLE INFORMATION (PII)

Personally Identifiable Information (PII) as defined at CFR Part 200.79 and 2 CFR 200.82 at will not be requested unless necessary and only with prior written approval of the AO with concurrence from the AOR.

D. AVAILABLE FUNDING

The cost of the work to be reimbursed by FHWA is Not to Exceed the amount in block 11 of the cover page, unless an amendment to the Agreement is made in writing and agreed to by both parties.

E. KEY PERSONNEL

Pursuant to 2 CFR 200.308(c)(2), the Recipient must request prior written approval from the AO for any change in Key Personnel specified in the award. The following person(s) are/have been identified as Key Personnel:

Name	Title/Position
None	

F. SUBAWARDS AND SUBCONTRACTS APPROVAL

The Recipient has been determined to have a procurement system that is approved and accepted by the Government, so are exempt from the requirements of 2 CFR §200.330.

G. ORDER OF PRECEDENCE

The Project MOA is accepted, approved, and incorporated herein as Attachment 1. In the event of any conflict between this agreement document and Project MOA, this Agreement document shall prevail.

H. DESIGNATION AS RESEARCH OR NON-RESEARCH AGREEMENT

This agreement is designated as: NON-RESEARCH

I. CONFERENCE SUPPORT RESTRICTIONS

The Recipient must obtain written approval from the AOR prior to incurring any costs for conference support. See the definition of conference as contained in 2 CFR 200.432.

Food and beverage costs are not allowable conference expenses for reimbursement under this Agreement.

Note: Costs of meals are allowable as a travel per diem expense for individuals on travel status and pursuant to the Travel clause of this Agreement.

J. DISPUTES

The parties to this Agreement will communicate with one another in good faith and in a timely and cooperative manner when raising issues under this provision. Any dispute, which for the purposes of this provision includes any disagreement or claim, between the FHWA and the Recipient concerning questions of fact or law arising from or in connection with this Agreement and whether or not involving alleged breach of this Agreement, may be raised only under this Disputes provision.

Whenever a dispute arises, the parties will attempt to resolve the issues involved by discussion and mutual agreement as soon as practical. In no event will a dispute which arose more than three months prior to the notification made under the following paragraph of this provision constitute the basis for relief under this article unless FHWA waives this requirement.

Failing resolution by mutual agreement, the aggrieved party will document the dispute by notifying the other party in writing of the relevant facts, identify unresolved issues and specify the clarification or remedy sought. Within five working days after providing written notice to the other party, the aggrieved party may, in writing, request a decision from the AO. The AO will conduct a review of the matters in dispute and render a decision in writing within thirty calendar days of receipt of such written request. Any decision of the AO is final and binding unless a party will, within thirty calendar days, request further review as provided below.

Upon written request to one level above the AO or designee, made within thirty calendar days after the AO’s written decision or upon unavailability of a decision within the stated time frame under the preceding paragraph, the dispute will be further reviewed. This review will be conducted by one level above the AO. Following the review, all parties will be notified in writing. Such resolution is not subject to further administrative review and to the extent permitted by law, will be final and binding. Nothing in this Agreement is intended to prevent the parties from pursuing disputes in a United States Federal Court of competent jurisdiction.

B.1.

14

CLACKAMAS COUNTY

DAN JOHNSON
DIRECTOR

DEPARTMENT OF TRANSPORTATION AND DEVELOPMENT
DEVELOPMENT SERVICES BUILDING
150 BEAVERCREEK ROAD OREGON CITY, OR 97045

July 11, 2019

Board of County Commissioner
Clackamas County

Members of the Board:

Approval of a Federal Lands Access Program Project Memorandum of Agreement with Western Federal Lands Highway Division for the Lolo Pass Road Stabilization and Surface Preservation Project

Purpose/Outcomes	The purpose of the agreement is to approve a Project Memorandum of Agreement for the Lolo Pass Road Stabilization and Surface Preservation Project.
Dollar Amount and Fiscal Impact	Overall Project Cost Estimate: $4,052,403 Federal Lands Access Program (FLAP) funds: $3,241,922 County minimum match (10.27%): up to $371,052 County overmatch: up to $439,429
Funding Source	FLAP Funds and County Road Funds.
Duration	Upon execution through summer of 2021
Previous Board Action	06/28/16: BCC Authorization to Apply for Federal Land Access Program Funding 02/15/18: BCC Authorization of the Federal Lands Access Program Match Agreement
Counsel Review	The agreement was reviewed by County Counsel on July 2, 2019
Strategic Plan Alignment	• Build a strong infrastructure
Contact Person	Joel Howie, Civil Engineering Supervisor 503-742-4658

BACKGROUND:
Clackamas County submitted a grant application to Western Federal Lands Highway Division (WFLHD) to stabilize and improve Lolo Pass Road by extending a section of existing revetment constructed as a part of the Lolo Pass Road Emergency Repair Project. The revetment construction is intended to reduce the likelihood that the Sandy River will leave its banks during the next flood event at this location. Additionally, Lolo Pass Road will receive a two-inch asphalt overlay along the entire 3.99 miles of road between Highway 26 and the Mount Hood National Forest Boundary to the north. The grant application's total estimated cost was $3,696,370 with a federal funding request of $3,316,753. During the grant review process, WFLHD added a ten percent construction phase contingency raising the grant's overall project cost estimate to $4,052,403.

WFLHD awarded the project $3,241,922 in federal funds, requiring a minimum County Match of 10.27 percent or $371,052. Up to an additional $439,429 in County funds will be required to complete the project as envisioned in the grant application. WFLHD's grant award decision was based on providing 80 percent of the project's total estimated cost. Although the grant award is less than the application's request, the revetment adjacent to Lolo Pass road described in the grant application is in need of stabilization, the entire road limits are in need of an asphalt overlay and leveraging the funds to pay for most of the project is prudent.

A Program Match Agreement was approved by the Board in February of 2018 to confirm the Clackamas County's intention to meet our grant award and match requirements. This agreement is required to identify the responsibilities between WFLHD and Clackamas County for the project.

RECOMMENDATION:
Staff respectfully recommends that the Board of County Commissioners approve the attached Match Agreement with WFLHD for the Lolo Pass Road Stabilization and Surface Preservation Project as listed in the agreement.

Respectfully submitted,

Joel Howie

Joel Howie,
Civil Engineering Supervisor

Federal Lands Access Program
Project Memorandum of Agreement

Project / Facility Name: Lolo Pass Road Stabilization and Surface Preservation, OR CLACK 37005(2)

Project Route: Clackamas County Road #37005

State: Oregon

County: Clackamas County

Owner of Federal Lands to which the Project Provides Access: United States Forest Service – Mt. Hood National Forest

Entity with Title or Maintenance Responsibility for Facility: Clackamas County

Type of Work:

- Preliminary Engineering
- NEPA / Permitting
- Rehabilitation
- Construction Engineering / Contract Administration

This Agreement does not obligate (commit to) the expenditure of Federal funds nor does it commit the parties to complete the project. Rather, this agreement sets forth the respective responsibilities as the project proceeds through the project development process.

Parties to this Agreement: Federal Highway Administration, Western Federal Lands Highway Division and Clackamas County

The Program Decision Committee approved this project on August 30, 2016.

AGREED:

Commissioner, Clackamas County — Date: 7-11-19 B.I.

Chief of Business Operations, FHWA - WFLHD — Date: 7.23.19

A. PURPOSE OF THIS AGREEMENT:

This Agreement documents the intent of the parties and sets forth the anticipated responsibilities of each party in the development, construction, and future maintenance of the subject project. The purpose of the Agreement is to identify and assign responsibilities for the environmental analysis, design, right-of-way, utilities, acquisition and construction as appropriate for this project, and to insure maintenance of the facility for public use if improvements are made. The parties understand that any final decision as to design or construction will not be made until after the environmental analysis required under the National Environmental Policy Act (NEPA) is completed (this does not prevent the parties from assigning proposed design criteria to be studied in the NEPA process.) Any decision to proceed with the design and construction of the project will depend on the availability of appropriations at the time of obligation and other factors such as issues raised during the NEPA process, a natural disaster that changes the need for the project, a change in Congressional direction, or other relevant factors.

If Federal Lands Access Program (FLAP) funds are used for the development or construction of this project, Clackamas County agrees to provide a matching share equal to 10.27% of the total cost of the project, as detailed more fully in Section J below. When agencies other than Federal Highway Administration – Western Federal Lands Highway Division will be expanding FLAP Funds, the parties agree to execute a separate obligating document. No reimbursement will be made for expenses incurred prior to execution of the obligating document.

B. AUTHORITY:

This Agreement is entered into between the signatory parties pursuant to the provisions of 23 U.S.C. 204.

C. JURISDICTION AND MAINTENANCE COMMITMENT:

The Clackamas County has jurisdictional authority to operate and maintain the existing facility and will operate and maintain the completed project at its expense.

D. FEDERAL LAND MANAGEMENT AGENCY COORDINATION:

Clackamas County has coordinated project development with the USFS – Mt. Hood National Forest. The USFS – Mt. Hood National Forest support of the project is documented by their endorsement of the project application OR FY16-14.

Each party to this agreement who has a primary role in NEPA, design or construction should coordinate their activities with the Federal Highway Administration – Western Federal Lands Highway Division.

E. PROJECT BACKGROUND / SCOPE:

Lolo Pass Road is the only paved access route to the Zig Zag District of the Mt. Hood National Forest and the community of Zig Zag. As a result, the Forest Service and Clackamas County residents are completely dependent upon Lolo Pass Road for access to the Mt. Hood National Forest and Zig Zag. Unfortunately, this critical access route is vulnerable to the unstable hydrology of the Sandy River, which is prone to flooding and periodic washouts. When washouts occur, the only alternative detour is over 30 miles of unpaved roads.

Lolo Pass Road is the access point for visitors seeking to enjoy the trails, campgrounds, fishing and scenic beauty of the Zig Zag Ranger District. Lolo Pass Road serves as an

important access point for the Pacific Crest Trail, as well as for several other trails with the Mt. Hood National Forest. In addition, there are three campgrounds accessed from Lolo Pass Road including a horse campground. Lolo Pass Road and the French's Dome Trail provide access to French's Dome, a popular rock climbing destination. Lolo Pass Road is also the western access for Mt. Hood and its glaciers.

Lolo Pass Road is of critical concern to the National Forest Service because it serves as the only paved access to the Mt. Hood National Forest Zig Zag Ranger District Headquarters. The Zig Zag Ranger District Headquarters is also the location of several maintenance and support facilities including the Rangers office, housing, District Fire Warehouse, and the Road and Trail Warehouse. The Fire Warehouse serves as a local base and support for firefighting. The Road and Trail Warehouse supports Forest Service road and trail maintenance activities in the area. Loss of Lolo Pass Road due to a flood event would not only prevent visitors from accessing this portion of the Mt. Hood National Forest, it would limit access to all the support facilities located at the Zig Zag Ranger District Headquarters and severely hamper on-going operations of this area of the national forest.

Washouts have occurred a number of times over the course of recent years due to flooding and/or channel migration by the Sandy River. The Upper Sandy River has experienced several major floods that caused substantial flooding, bank erosion and damage to Lolo Pass Road. During the 50 years between 1964 and 2014 the river has experienced 8 of the 10 highest peak flows in its 100 year flow record. The flood of record occurred in 1964 and had a flow of 61,400 cubic feet per second. This event completely destroyed the Sandy River Bridge on Lolo Pass Road as well as several other sections of the road. Damaging floods also occurred in 1996 and 2011 resulting in the loss of several additional sections of the road.

During the January 2011 event the Sandy River eroded the roadway embankment at a location about 0.23 miles north of its intersection with E. Barlow Trail Road, washed out approximately 300 feet of Lolo Pass Road, and ran south along the roadway, destroying several houses. A total of 1/2 mile of Lolo Pass Road was washed out. This washout closed the road for over four months.

As a result of this event Clackamas County repaired the damaged section of the road, rechanneled a section of the Sandy River and stabilized the banks with riprap and plantings with added large woody debris for riparian and fish habitat. This returned the road to service and helped reduce the likelihood of the river leaving its channel at that location during future flood events. However, there was not sufficient funding available at the time to completely overlay the road or construct a revetment that protected the entire portion of the west bank where the river left its channel. While these actions returned the road to service and addressed the immediate issues with the river channel, it was not sufficient to prevent the Sandy River from leaving its channel at this location or to protect the road from washout should another flood event occur.

This project undertakes two steps that should help prevent the river from leaving its channel and protect the road from potential washouts. To address these vulnerabilities the existing west bank revetment will be extended 300 feet upstream, and add a 2 inch overlay of the entire road will be added to protect the existing breaks and joints in the road surface from being undermined by future flooding. The extension of the revetment will protect the entire area that experienced bank erosion during the 2011 flood event. The overlay paving will seal the joints that remain exposed from previous patching and reduce the likelihood of failure in those locations during future floods.

F. PROJECT BUDGET:

This is the anticipated budget for the project based on information developed to date. Federal Lands Access Program funds in conjunction with matching funds provided by Clackamas County will fund this project as detailed in Section K.

Phase	FLAP Funds			Partner Match		Total
	To FHWA	To CC	Total	From CC	Total	
PE	$10,000	$0	$10,000	$220,000	$220,000	$230,000
CE	$10,000	$0	$10,000	$151,061	$151,061	$161,061
CN/CM	$0	$3,221,992	$3,221,992	$0	$0	$3,221,992
	$20,000	$3,221,992	$3,241,992	$371,061	$371,061	$3,613,053

Note: The total match is calculated on the total FLAP funds provided. However, the total project cost is $4,052,403. The FLAP amount is limited to $3,241,992.

G. ROLES AND RESPONIBILITIES:

Clackamas County will provide full support in the NEPA and environmental review process. This includes, but is not limited to: obtaining permits, providing documentation to support NEPA, Endangered Species Act (ESA), and Section 106 compliance, performing studies, etc. FHWA will be responsible for making the NEPA decision.

Clackamas County will administer the other phases of project development such as survey, geotechnical investigation (if required), hydraulic investigation (if required) right-of-way plan preparation (if required), preliminary and final design. The project will be designed to AASHTO Standards. Clackamas County will obtain, or will require the contractor to obtain, all necessary Federal, State, or local permits.

Clackamas County will be responsible for the acquisition of any rights-of-way, easements and / or permits necessary to complete the project. Clackamas County will not initiate right-of-way acquisition until FHWA has written an environmental decision document.

Although not expected, prior to Clackamas County soliciting bids for the project, Clackamas County will certify to FHWA that all right-of-way appraisals and acquisitions have been performed in accordance with the Uniform Relocation Assistance and Real Properties Acquisition Policies Act of 1970 and the Uniform Relocation Act Amendments of 1987.

Although not expected, Clackamas County will be responsible for the relocation of any utilities necessary to complete the project. In accordance with 23 CFR PART 645.103; any applicable reimbursement to the utility company will be governed by State and federal Laws and regulations, or Occupancy Permits. Utility relocation costs will be reimbursable under the construction costs for the project.

During the construction phase, Clackamas County will appoint a Project Engineer to oversee and inspect the work to ensure a quality product. The construction will be governed by the Oregon Standard Specifications for Construction, 2015 Edition.

Clackamas County will be responsible for the following:

- Appointing a representative who will be the primary contact for FHWA's Project Manager.

- Project activities identified in Section P.
- Provide appropriate match to all FLAP funds expended on the project even if the project is terminated prior to completion.
- Upon completion of construction, provide copies of final inspection demonstrating the project has been constructed in substantial conformity with the approved plans and specifications.
- Provide written confirmation of its final acceptance of the constructed project.
- Compliance with terms and conditions as noted in 2 CFR 200 Common Rule Requires.

FHWA will be responsible for the following:

- Stewardship and oversight activities identified in Section P.
- FHWA decisions that may not be delegated, identified in Section P.

H. ROLES AND RESPONSIBILITIES – SCHEDULE:

Responsible Lead	Product/Service	Schedule Finish
Clackamas County	30% Design	August 2019
Clackamas County	Environmental Reviews and Studies	February 2020
FHWA	NEPA Decision	May 2020
Clackamas County	Final Design	December 2020
Clackamas County	Construction	Summer 2021

I. PROPOSED DESIGN STANDARDS:

Preferred design alternatives will be determined through the NEPA process. The following design criteria will be applied on the project:

Criteria		Comments
Standard Design	AASHTO	Oregon Standard Drawings
Functional Classification	Arterial	
Surface Type	Asphalt	
Design Volume	2,375	ADT = 2,375 at BOP, 1,150 at EOP for 20 year projection, currently at 1,950 at BOP, 950 at EOP

J. FUNDING:

The project is partially funded by the Federal Lands Access Program administered by FHWA-WFL, with matching funds and additional funds provided by Clackamas County.

Fund Source	Amount	Comments
Title 23 FLAP funds – K200	PE - $10,000 CE - $10,000 CN - $3,221,922	The PDC agreed to provide $3,241,922 of funding including $20,000 for S/O and NEPA

Local Matching Share – Clackamas County (10.27%)	$371,061	In-kind services
Additional funds – Clackamas County	$439,420	
TOTAL	$4,052,403	

K. MATCHING SHARE REQUIREMENTS:

The purpose of this section is to document the intent of Clackamas County to meet its match requirement for the subject project as authorized under Section 23 USC 201(b)(7)(B). All FLAP expenditures associated with this project will need to be matched by a non-Federal sources, other Federal funds other than those made available under Title 23 and 49 of the United States Code, or by funds made available under 23 USC 202 and 203. The matching requirement under the FAST Act will be met by Clackamas County

Clackamas County has committed to the project. The forms of match shall be those consistent with the "Federal-Aid Guidance Non-Federal Matching Requirements" and as approved by FHWA-WFL. In the state of Oregon, 10.27% of the total project cost.

This project is authorized to use a Tapered Match. Under this approach, the non-Federal match is imposed over the entire project rather than individual progress payments. Timing of all fund transfers are specified under the Funding Plan. Tapered Match is authorized because it will result in an earlier completion date.

Estimated cost and fiscal year (FY) for the funding are based on the best budgeting and scheduling information known at the time. The final match will be determined based on actual expenditures at the conclusion of the project work. Matching cash funds in FWHA-WFL receipt may need to be supplemented, or returned, once actual expenditures are determined. As noted under Modifications, if cost increase over the amount within this agreement, FHWA-WFL will consult with the agency providing match before granting approval.

Maintain all project records, including source documentation for all expenditures and in-kind contributions, for a period of three (3) years from the date of final acceptance. If any litigation claim, negotiation, or audit has been started before expiration of the three-year period, the records shall be retained until completion of the action or resolution of all issues that arise from it.

The following agencies have agreed to contribute the amounts showing which will reduce the federal share by the same amount. The funding plan is as follows:

Agency	Phase	Form	Due	Value	Comments
Clackamas County	PE/CN	In-Kind Services	7/1/2020	$371,061	This is to match the FLAP amount, additional funds are needed to complete the project

L. PROJECT TEAM MEMBERS – POINT OF CONTACT:

The following table provides the points of contact for this project. They are to be the first persons to deal with any issues or questions that arise over the implementation of each party's role and responsibility for this agreement.

Name & Title	Agency	Phone & Email
Joel Howie, Civil Engineering Supervisor	Clackamas County	503-742-4658 jhowie@co.clackamas.or.us
Neal Christensen, Program Manager	FHWA	360-619-7780 Neal.christensen@dot.gov

M. CHANGES / AMENDMENTS / ADDENDUMS:

The agreement may be modified, amended, or have addendums added by mutual agreement of all parties. The change, amendment, or addendum must be in writing and executed by all parties.

Potential changes include, but are not limited to, changes that significantly impact scope, schedule, or budget; changes to the local match, either in type or responsibility; change that alter the level of effort or responsibilities of a party. The parties commit to consider suggested changes in good faith. Failure to reach agreement on changes may be cause for termination of this agreement.

A change in composition of the project team members does not require the agreement to be amended.

It is the responsibility of the project team members to recognize when changes are needed and to make timely notifications to their management in order to avoid project delivery delays.

N. ISSUE RESOLUTION PROCEDURES MATRIX:

Issues should be resolved at the lowest level possible. The issue should be clearly defined in writing and understood by all parties. Escalating to the next level can be requested by any party. When an issue is resolved, the decision will be communicated to all levels below.

FHWA	Clackamas County	Time
Neal Christensen Program Manager neal.christensen@dot.gov 360-619-7780	Joel Howie, Civil Engineering Supervisor jhowie@co.clackamas.or.us 503-742-4658	15 Days
Pete Field Environment, Planning and Programming Branch Chief Peter.field@dot.gov 360-619-7619	Mike Bezner, Assistant Director of Transportation mikebez@clackamas.us 503-742-7651	15 Days
Dan Donovan Chief of Business Operations Daniel.donovan@dot.gov 360-619-7966	Dan Johnson, Director of Transportation danjoh@clackamas.us 503-742-4326	15 Days

O. TERMINATION:

This agreement may be terminated by mutual written consent of all parties. This agreement may also be terminated if either the NEPA process or funding availability requires a change and the parties are not able to agree to the change. Any termination of this agreement shall not prejudice any rights or obligations accrued to the parties prior to termination. If Federal access funds have been expended prior to termination, the party responsible for the match agrees to provide a match in the applicable percentage of the total amount expended on the project prior to the termination.

P. STEWARDSHIP & OVERSIGHT ACTIVITIES:

Phase	Activity	Roles		Comments
		Clackamas County	FHWA	
Planning & Programming	Design exception approval agency identified	Provide	Approve	
Planning & Programming	Evidence of funding allocation	Signed Match Agreement	File copy	Completed
Planning & Programming	Memorandum of Agreement with scope, schedule, & budget	Signed MOA	File copy	
Environment	Identify NEPA contact		Provide	FHWA must be a lead agency on NEPA
Environment	Complete all environmental documents necessary for FHWA to develop an environmental decision (ESA, Section 106, 4F, etc.)	Provide	Review and prepare environmental decision	
Environment	NEPA – Tribal coordination		Provide	FHWA must perform this task
Environment	Obtain environmental permits	Provide	File copy	
Environment	Attend public meetings	Notify	Attend as determined by FHWA	
Environment	FHWA NEPA decision	Comply	Provide	FHWA approval needed
Design	Complete 30% PS&E	Provide	Concur	Completed
Design	Complete 95% PS&E	Provide	Approve	Must have written approval by FHWA
Design	Review or approve design exceptions	Provide	Approve	Follow ODOT's process
Acquisitions	Approval of proprietary products	Provide	Approve	
Acquisitions	Contract package for required clauses (Civil Rights, Davis Bacon, Buy America/American, etc.)	Provide	Approve	
Acquisitions	Receive copy of award package	Provide	File copy	
Acquisitions	Review and approve contract modifications	Provide	Approve	
Construction	Attend Pre-Construction Meeting	Attend	Attend as determined by FHWA	

Construction	Final Project Inspections	Attend	Attend as determined by FHWA	
Construction	Construction photographs of project, before, during (quarterly) and post construction	Provide	File	
Construction	Copy of As-Builts	Provide	File	
Construction	Contract disputes (Claims)	Provide	Review and Provide assistance as warranted	
Construction	Copy of Final Construction Acceptance Letter and report	Provide	Review	

Oregon
Kate Brown, Governor

Department of Transportation
Financial Services Branch
355 Capital Street NE MS #21
Salem OR 97301
Phone: (503) 986-3900
Fax: (503) 986-3907

CENTRAL SERVICE ALLOCATION PLAN
July 1, 2019 – June 30, 2020

May 14, 2019

Clackamas County
Attn: Jian Zhang
2051 Kaen Road
Oregon City, OR 97045

As outlined by the Office of Management and Budget (OMB) in 2 CFR Part 200 (formerly OMB Circular A-87 and 2 CFR 225), the Oregon Department of Transportation (ODOT) recommends the Clackamas County Central Service Cost Allocation Rates cited in this agreement for fiscal year ending June 30, 2020.

Since ODOT is not an authorized federal cognizant audit agency, the cost rates below are for use on federal grants and contracts administered by ODOT with the federal government grants and contracts to which 2 CFR Part 200 applies. The rate was negotiated by Clackamas County and ODOT according to the authority contained in Appendix VII, Section D.1b of 2 CFR Part 200. Other entities may use this rate as the costs presented are in accordance with OMB 2 CFR Part 200.

The rate delineated in this section is effective for the period of July 1, 2019 through June 30, 2020. The rate is applicable to all programs exclusive of "pass-through" programs or those exempt by law.

Indirect Costs, Direct Costs and Central Service Allocations were based on actual expenditures for the 2017-2018 fiscal year.

ODOT accepts the submitted indirect cost rates from the county, no adjustments are proposed. Indirect rates shall be applied to direct salary & wages.

Below is list of Clackamas County Division's approved indirect cost rates for ODOT purposes.

Transportation Construction	35.35%
Transportation Maintenance	38.93%
Transportation Safety	40.93%
Long Range Planning	40.67%
Development Agency	43.63%
Land Use, Dev & Permitting, Road Fund	26.70%

The rates in this agreement should be allocated to all Federal grant programs and contracts for the effective period. Costs allocable to programs which restrict reimbursement of indirect costs may not be allocated to other participating programs.

For the Oregon Department of Transportation	*For Clackamas County*
Tracy Wroblewski	
Tracy Wroblewski *Chief Financial Officer*	*Christa Bosserman Wolfe* *Finance Director*
5-17-19	5/17/19
Date	*Date*

CLACKAMAS COUNTY

DAN JOHNSON
DIRECTOR

DEPARTMENT OF TRANSPORTATION AND DEVELOPMENT
DEVELOPMENT SERVICES BUILDING
150 BEAVERCREEK ROAD OREGON CITY, OR 97045

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of a Contract with Kerr Contractors Oregon, Inc. for
Realignment of Victory Road at Forsythe Road

Purpose/Outcomes	This Contract will relocate the Victory Road at Forsythe Road intersection, which will correct a severe skew that currently has limited site distance.
Dollar Amount and Fiscal Impact	Contract value is $451,122.00
Funding Source	215-7432-02101-481200-22240 County funds: $409,122.00 Developer conditions of approval funds: $42,000.00
Duration	Contract execution through June 30, 2019
Previous Board Action	N/A
Strategic Plan Alignment	This project will provide strong infrastructure and ensure safe communities by maintaining the County's existing road infrastructure.
Counsel Approval	This Contract was reviewed and approved by Count Counsel on August 19, 2019
Contact Person	Bob Knorr, Project Manager 503-742-4680

Background:
The County worked with the adjacent property owner/developer to dedicate property for the relocation of Victory Road at Forsythe Road intersection approximately 700 feet to the west of the existing intersection. The existing intersection has a severe skew with limited site distance and experiences periodic crashes. Construction of the project is funded by County Road Fund and $42,000 in the adjacent developer's condition of approval for development.

This project includes constructing approximately 950 feet of a new section of Victory Road and overlaying approximately 250 feet on Forsythe Road to provide adequate site distance at the intersection. The project includes 550 tons of asphalt concrete pavement, 1,459 tons of aggregate base, 53 tons of aggregate shoulders, 144 feet of 31 inch high guardrail, 1,169 cubic yards of general excavation, a water quality facility, and 186 linear feet of various sizes and types of storm pipe.

The project work is anticipated to begin immediately following contract signing. Substantial completion will be not later than October 31, 2019 with final completion not later than June 30, 2020 to allow for seed establishment.

Procurement Process:
This project was advertised in accordance with ORS and LCRB Rules on June 13, 2019. Bids were opened on July 10, 2019. The County received three (3) bids: Banzer Construction, $497,673.50; Braun Construction, $462,380.00; and Kerr Contractors Oregon, Inc., $451,122.00. Kerr Contractors

Oregon, Inc. was determined to be the lowest responsive bidder and was below the engineer's estimate of $455.414.00.

Recommendation:

Staff respectfully recommends that the Board approves and signs this public improvements contract with Kerr Contractors Oregon, Inc. for the Realignment of Victory Road at Forsythe Road.

Sincerely,

Mike Bezner,
Assistant Director,
Department of Transportation and Development

Placed on the BCC Agenda _____ by Procurement

CLACKAMAS COUNTY
PUBLIC IMPROVEMENT CONTRACT
Contract #1787

This Public Improvement Contract (the "Contract"), is made by and between the Clackamas County, a political subdivision of the State of Oregon, hereinafter called "Owner," and **Kerr Contractors Oregon, LLC**, hereinafter called the "Contractor" (collectively the "Parties"), shall become effective on the date this Contract has been signed by all the Parties and all County approvals have been obtained, whichever is later.

Project Name: #2019-46 Realignment of Victory Road at Forsythe Road

1. Contract Price, Contract Documents and Work.
The Contractor, in consideration of the sum of **four hundred fifty-one thousand one hundred twenty-two dollars ($451,122.00)** (the "Contract Price"), to be paid to the Contractor by Owner in the manner and at the time hereinafter provided, and subject to the terms and conditions provided for in the Instructions to Bidders and other Contract Documents (as defined in the project specifications) referenced within the Instructions to Bidders), all of which are incorporated herein by reference, hereby agrees to perform all Work described and reasonably inferred from the Contract Documents. The Contract Price is the amount contemplated by the Base Bid, as indicated in the accepted Bid.

Also, the following documents are incorporated by reference in this Contract and made a part hereof:

- Notice of Contract Opportunity
- Supplemental Instructions to Bidders
- Bid Form
- Performance Bond and Payment Bond
- Payroll and Certified Statement Form
- Addendum #1
- Instructions to Bidders
- Bid Bond
- Public Improvement Contract Form
- Prevailing Wage Rates
- Plans, Specifications and Drawings

The Plans, Specifications and Drawings expressly incorporated by reference into this Contract includes, but is not limited to, the Special Provisions for Highway Construction (the "Specifications"), together with the provisions of the Oregon Standard Specifications for Construction (2018) referenced therein.

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 material breach that entitles County to exercise any rights and remedies available under this Contract including, but not limited to, termination for default

2. Representatives.
Contractor has named Alan W. Aplin as its Authorized Representative to act on its behalf. Owner designates, or shall designate, its Authorized Representative as indicted below (check one):

☒ Unless otherwise specified in the Contract Documents, the Owner designates Bob Knorr as its Authorized Representative in the administration of this Contract. The above-named individual shall be the initial point of contact for matters related to Contract performance, payment, authorization, and to carry out the responsibilities of the Owner.

☐ Name of Owner's Authorized Representative shall be submitted by Owner in a separate writing.

3. Key Persons.
The Contractor's personnel identified below shall be considered Key Persons and shall not be replaced during the project without the written permission of Owner, which shall not be unreasonably withheld. If the

Contractor intends to substitute personnel, a request must be given to Owner at least 30 days prior to the intended time of substitution. When replacements have been approved by Owner, the Contractor shall provide a transition period of at least 10 working days during which the original and replacement personnel shall be working on the project concurrently. Once a replacement for any of these staff members is authorized, further replacement shall not occur without the written permission of Owner. The Contractor's project staff shall consist of the following personnel:

Project Executive: Carl Nelson shall be the Contractor's project executive, and will provide oversight and guidance throughout the project term.

Project Manager: David Finnigan shall be the Contractor's project manager and will participate in all meetings throughout the project term.

Job Superintendent: Chris Martinez shall be the Contractor's on-site job superintendent throughout the project term.

Project Engineer: Steve Cespedes shall be the Contractor's project engineer, providing assistance to the project manager, and subcontractor and supplier coordination throughout the project term.

4. Contract Dates.

COMMENCEMENT DATE: Upon Issuance of Notice to Proceed ("NTP")
SUBSTANTIAL COMPLETION DATE: October 31, 2019
FINAL COMPLETION DATE: June 30, 2020

Time is of the essence for this Contract. It is imperative that the Work in this Contract reach Substantial Completion and Final Completion by the above specified dates.

5. Insurance Certificates and Required Performance and Payment Bonds.

5.1 In accordance with Section 00170.70 of the Specifications, Contractor shall furnish proof of the required insurance naming Clackamas County as an additional insured. Insurance certificates may be returned with the signed Contract or may be emailed to Procurement@clackamas.us.

5.2 Primary Coverage: Insurance carried by Contractor under the Contract shall be the primary coverage. The coverages indicated are minimums unless otherwise specified in the Contract Documents.

5.2.1 Workers' Compensation: All employers, including Contractor, that employ subject workers who work under the Contract in the State of Oregon shall comply with ORS 656.017 and provide the required Workers' Compensation coverage, unless such employers are exempt under ORS 656.126. This shall include Employer's Liability Insurance with coverage limits of not less than the minimum amount required by statute for each accident. Contractors who perform the Work without the assistance or labor of any employee need not obtain such coverage if the Contractor certifies so in writing. Contractor shall ensure that each of its Subcontractors complies with these requirements. The Contractor shall require proof of such Workers' Compensation coverage by receiving and keeping on file a certificate of insurance from each Subcontractor or anyone else directly employed by either the Contractor or its Subcontractors.

5.3 Builder's Risk Insurance: During the term of the Contract, for new construction the Contractor shall obtain and keep in effect Builder's Risk insurance on an all risk forms, including earthquake and flood, for an amount equal to the full amount of the Contract, plus any changes in values due to

modifications, Change Orders and loss of materials added. Such Builder's Risk shall include, in addition to earthquake and flood, theft, vandalism, mischief, collapse, transit, debris removal, and architect's fees “soft costs” associated with delay of Project due to insured peril. Any deductible shall not exceed $50,000 for each loss, except the earthquake and flood deductible which shall not exceed 2 percent of each loss or $50,000, whichever is greater. The deductible shall be paid by Contractor. The policy will include as loss payees Owner, the Contractor and its Subcontractors as their interests may appear.

5.4 Builder's Risk Installation Floater: For Work other than new construction, Contractor shall obtain and keep in effect during the term of the Contract, a Builder's Risk Installation Floater for coverage of the Contractor's labor, materials and equipment to be used for completion of the Work performed under the Contract. The minimum amount of coverage to be carried shall be equal to the full amount of the Contract. The policy will include as loss payees Owner, the Contractor and its Subcontractors as their interests may appear. Owner may waive this requirement at its sole and absolute discretion.

5.4.1 Such insurance shall be maintained until Owner has occupied the facility.

5.4.2 A loss insured under the Builder’s Risk insurance shall be adjusted by the Owner and made payable to the Owner as loss payee. The Contractor shall pay Subcontractors their just shares of insurance proceeds received by the Contractor, and by appropriate agreements, written where legally required for validity, shall require Subcontractors to make payments to their Sub-subcontractors in similar manner. The Owner shall have power to adjust and settle a loss with insurers.

5.5 "Tail" Coverage: If any of the required liability insurance is arranged on a "claims made" basis, "tail" coverage will be required at the completion of the Contract for a duration of 36 months or the maximum time period available in the marketplace if less than 36 months. Contractor shall furnish certification of "tail" coverage as described or continuous "claims made" liability coverage for 36 months following Final Completion. Continuous "claims made" coverage will be acceptable in lieu of "tail" coverage, provided its retroactive date is on or before the effective date of the Contract. Owner’s receipt of the policy endorsement evidencing such coverage shall be a condition precedent to Owner’s obligation to make final payment and to Owner’s final acceptance of Work or services and related warranty (if any).

5.6 Notice of Cancellation or Change: If the Contractor receives a non-renewal or cancellation notice from an insurance carrier affording coverage required herein, or receives notice that coverage no longer complies with the insurance requirements herein, Contractor agrees to notify Owner by fax within five (5) business days with a copy of the non-renewal or cancellation notice, or written specifics as to which coverage is no longer in compliance. When notified by Owner, the Contractor agrees to stop Work pursuant to the Contract at Contractor’s expense, unless all required insurance remain in effect. Any failure to comply with the reporting provisions of this insurance, except for the potential exhaustion of aggregate limits, shall not affect the coverages provided to the Owner and its institutions, divisions, officers, and employees.
Owner shall have the right, but not the obligation, of prohibiting Contractor from entering the Project Site until a new certificate(s) of insurance is provided to Owner evidencing the replacement coverage. The Contractor agrees that Owner reserves the right to withhold payment to Contractor until evidence of reinstated or replacement coverage is provided to Owner.

5.7 Before execution of the Contract, the Contractor shall file with the Construction Contractors Board, and maintain in full force and effect, the separate public works bond required by Oregon Revised Statutes, Chapter 279C.830 and 279C.836, unless otherwise exempt under those provisions.

The Contractor shall also include in every subcontract a provision requiring the Subcontractor to have a public works bond filed with the Construction Contractors Board before starting Work, unless otherwise exempt, and shall verify that the Subcontractor has filed a public works bond before permitting any Subcontractor to start Work.

5.8 When the Contract Price is $50,000 or more, the Contractor shall furnish and maintain in effect at all times during the Contract Period a performance bond in a sum equal to the Contract Price and a separate payment bond also in a sum equal to the Contract Price. Contractor shall furnish such bonds even if the Contract Price is less than the above thresholds if otherwise required by the Contract Documents.

5.9 Bond forms furnished by the Owner and notarized by Contractor's surety company authorized to do business in Oregon are the only acceptable forms of performance and payment security, unless otherwise specified in the Contract Documents.

6. Responsibility for Damages/Indemnity.

6.1 Contractor shall be responsible for all damage to property, injury to persons, and loss, expense, inconvenience, and delay that may be caused by, or result from, the carrying out of the Work to be done under the Contract, or from any act, omission or neglect of the Contractor, its Subcontractors, employees, guests, visitors, invitees and agents.

6.2 To the fullest extent permitted by law, Contractor shall indemnify, defend (with counsel approved by Owner) and hold harmless the Owner and its elected officials, officers, directors, agents, and employees (collectively "Indemnitees") from and against all liabilities, damages, losses, claims, expenses, demands and actions of any nature whatsoever which arise out of, result from or are related to: (a) any damage, injury, loss, expense, inconvenience or delay described in this Section 6.1; (b) any accident or occurrence which happens or is alleged to have happened in or about the Project Site or any place where the Work is being performed, or in the vicinity of either, at any time prior to the time the Work is fully completed in all respects; (c) any failure of the Contractor to observe or perform any duty or obligation under the Contract Documents which is to be observed or performed by the Contractor, or any breach of any agreement, representation or warranty of the Contractor contained in the Contract Documents or in any subcontract; (d) the negligent acts or omissions of the Contractor, a Subcontractor or anyone directly or indirectly employed by them or any one of them or anyone for whose acts they may be liable, regardless of whether or not such claim, damage, loss or expense is caused in part by a party indemnified hereunder (except to the extent otherwise void under ORS 30.140); and (e) any lien filed upon the Project or bond claim in connection with the Work. Such obligation shall not be construed to negate, abridge, or reduce other rights or obligations of indemnity which would otherwise exist as to a party or person described in this Section 6.2.

6.3 In claims against any person or entity indemnified under Section 6.2 by an employee of the Contractor, a Subcontractor, anyone directly or indirectly employed by them or anyone for whose acts they may be liable, the indemnification obligation under Section 6.2 shall not be limited on amount or type of damages, compensation or benefits payable by or for the Contractor or a Subcontractor under workers' compensation acts, disability benefit acts or other employee benefit acts.

7. Tax Compliance.

Contractor must, throughout the duration of this Contract and any extensions, comply with all tax laws of this state and all applicable tax laws of any political subdivision of this state. Any violation of this section shall constitute a material breach of this Contract. Further, any violation of Contractor's warranty in this Contract that Contractor has complied with the tax laws of this state and the applicable tax laws of any political subdivision of this state also shall constitute a material breach of this Contract. Any violation 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, at law, or in equity, including but not limited to: (A) Termination of this Contract, in whole or in part; (B) Exercise of the right of setoff, and withholding of amounts otherwise due and owing to Contractor, in an amount equal to County's setoff right, without penalty; and (C) Initiation of an action or proceeding for damages, specific performance, declaratory or injunctive relief. County shall be entitled to recover any and all damages suffered as the result of Contractor's breach of this Contract, including but not limited to direct, indirect, incidental and consequential damages, costs of cure, and costs incurred in securing replacement performance. These remedies are cumulative to the extent the remedies are not inconsistent, and County may pursue any remedy or remedies singly, collectively, successively, or in any order whatsoever.

The Contractor represents and warrants that, for a period of no fewer than six calendar years preceding the effective date of this Contract, has faithfully complied with: (A) All tax laws of this state, including but not limited to ORS 305.620 and ORS chapters 316, 317, and 318; (B) Any tax provisions imposed by a political subdivision of this state that applied to Contractor, to Contractor's property, operations, receipts, or income, or to Contractor's performance of or compensation for any work performed by Contractor; (C) Any tax provisions imposed by a political subdivision of this state that applied to Contractor, or to goods, services, or property, whether tangible or intangible, provided by Contractor; and (D) Any rules, regulations, charter provisions, or ordinances that implemented or enforced any of the foregoing tax laws or provisions.

8. Confidential Information.
Contractor acknowledges that it and its employees or agents may, in the course of performing their responsibilities under this Contract, be exposed to or acquire information that is confidential to Owner. Any and all information of any form obtained by Contractor or its employees or agents in the performance of this Contract shall be deemed confidential information of Owner ("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 purpose unless specifically authorized in writing under this Contract.

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

10. Integration.
All provisions of state law required to be part of this Contract, whether listed in the General or Special Conditions or otherwise, are hereby integrated and adopted herein. Contractor acknowledges the obligations thereunder and that failure to comply with such terms is a material breach of this Contract.

The Contract Documents constitute the entire agreement between the parties. There are no other understandings, agreements or representations, oral or written, not specified herein regarding this Contract. Contractor, by the signature below of its authorized representative, hereby acknowledges that it has read this Contract, understands it, and agrees to be bound by its terms and conditions.

11. Liquidated Damages
The Contractor acknowledges that the Owner will sustain damages as a result of the Contractor's failure to substantially complete the Project in accordance with the Contract Documents. These damages may include, but are not limited to delays in completion, use of the Project, and costs associated with Contract administration and use of temporary facilities.

11.1 Liquidated Damages shall be as follows if the actual Substantial Completion exceeds the required date of Substantial Completion:

11.1.1. $ 600.00 per Calendar day past the Substantial Completion date as identified in section 00180.85 (b) and 00180.85 (c).

12. Compliance with Applicable Law. Contractor shall comply with all federal, state, county, and local laws, ordinances, and regulations applicable to the Work to be done under this Contract including, but not limited to, compliance 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 material breach that entitles County to exercise any rights and remedies available under this Contract including, but not limited to, termination for default.

In witness whereof, Clackamas County executes this Contract and the Contractor does execute the same as of the day and year first above written.

Contractor DATA:
Kerr Contractors Oregon, LLC
P.O. Box 1060
Woodburn, Oregon 97071

Contractor CCB # 227664 Expiration Date: 8/27/21
Oregon Business Registry # 687808-90 Entity Type: DLLC State of Formation: Oregon

Payment information will be reported to the IRS under the name and taxpayer ID# provided by the Contractor. Information must be provided prior to contract approval. Information not matching IRS records could subject Contractor to 28 percent backup withholding.

Kerr Contractors Oregon, LLC	Clackamas County Board of County Commissioners
_____	_____
Authorized Signature Date	Chair Date
_____	_____
Name / Title Printed	Recording Secretary
	APPROVED AS TO FORM
	_____
	County Counsel Date

DRAFT

Approval of Previous Business Meeting Minutes:

June 27, 2019
July 11, 2019
July 18, 2019
July 25, 2019

BOARD OF COUNTY COMMISSIONERS BUSINESS MEETING MINUTES

A complete video copy and packet including staff reports of this meeting can be viewed at https://www.clackamas.us/meetings/bcc/business

Thursday, June 27, 2019 – 10:00 AM
Public Services Building
2051 Kaen Rd., Oregon City, OR 97045

PRESENT: Commissioner Jim Bernard, Chair
Commissioner Ken Humberston
Commissioner Paul Savas
Commissioner Martha Schrader
Commissioner Sonya Fischer

CALL TO ORDER

- Roll Call
- Pledge of Allegiance

I. CITIZEN COMMUNICATION

https://www.clackamas.us/meetings/bcc/business

1. Mario Mamone, West Linn – representing Maritime Café – would like the Board to change dispensary hours of operation.

The Board stated at this time they will not be changing this policy.

2. Steve Hocland, Damascus – Damascus incorporation issue – hope the parties can find level ground.
3. Bill Wehr, Damascus – Damascus issue.
4. Jim DeYoung, Damascus – Damascus issue.
5. Denise McGriff, Oregon City – asking for support for Clackamas County Heritage.

II. PUBLIC HEARINGS

1. Second Reading of Ordinance No. 02-2019 Amending the Clackamas Industrial Area Development Plan - *1st Reading was 5-9-19, 2nd Reading was 6-13-19 and tabled for a future date.*

Dave Queener, Development Agency presented the staff report.

~Board Discussion~

Chair Bernard opened the public hearing and asked for public comment.

1. Brett Sherman, Happy Valley City Council spoke in support of this ordinance. He also spoke about the importance of affordable housing in Happy Valley.

Chair Bernard stated the Board has met with Happy Valley Mayor, City Council and City Staff regarding moving forward with this issue. He then asked for a motion.

MOTION:

Commissioner Schrader: I move we read the Ordinance by title only.
Commissioner Humberston: Second.
all those in favor/opposed:
Commissioner Fischer: Aye.
Commissioner Humberston: Aye.
Commissioner Savas: Aye.
Commissioner Schrader: Aye.
Chair Bernard: Aye – the Ayes have it, the motion carries 5-0.

Chair Bernard asked the Clerk read the Ordinance by title only, then asked for a motion to adopt.

MOTION:

Commissioner Schrader. I move we adopt Ordinance No. 02-2019 Amending the Clackamas Industrial Area Development Plan.
Commissioner Humberston: Second.
all those in favor/opposed:
Commissioner Fischer: Aye.
Commissioner Humberston: Aye.
Commissioner Savas: Aye.
Commissioner Schrader: Aye.
Chair Bernard: Aye – the Ayes have it, the motion carries 5-0.

II. PUBLIC HEARINGS (continue)

2. **Resolution No. 2019-62** Adopting the Clackamas County Budget for the 2019-2020 Fiscal Year, Making Appropriations and Imposing and Categorizing Taxes for the Period of July 1, 2019 through June 30, 2020

Jennifer Chambers, Budget Manager presented the staff report.
Chair Bernard opened the public hearing and asked if anyone wishes to speak, seeing none he closed the public hearing and asked for a motion.

MOTION:

Commissioner Humberston: I move we approve the action and adopt the 2018-2019 budget for Clackamas County as presented in the Resolution.
Commissioner Schrader: Second.

~Board Discussion~ www.clackamas.us/meetings/bcc/business
Commissioner Fischer declared a potential conflict.
Commissioner Humberston thanked staff.
Commissioner Schrader thanked staff.
Chair Bernard declared a potential conflict.
Commissioner Savas thanked staff.

~Additional Board Discussion~ www.clackamas.us/meetings/bcc/business

all those in favor/opposed:
Commissioner Fischer: Aye.
Commissioner Humberston: Aye.
Commissioner Schrader: Aye.
Commissioner Savas: No.
Chair Bernard: Aye – the Ayes have it, the motion carries 4-1.

3. **Resolution No. 2019-63** Adopting Changed Fees for Clackamas County for Fiscal Year 2019-2020

Stephen Madkour, County Counsel presented the staff report.
Chair Bernard opened the public hearing and asked if anyone wished to speak, seeing none he closed the public hearing.
~Board Discussion~
Chair Bernard asked for a motion.

MOTION:

Commissioner Humberston: I move we approve and adopt the changed fees and fines for Clackamas County Fiscal Year 2018-2019 as presented in the Resolution.
Commissioner Schrader: Second.
all those in favor/opposed:
Commissioner Fischer: Aye.
Commissioner Humberston: Aye.
Commissioner Schrader: Aye.
Commissioner Savas: Aye.
Chair Bernard: Aye – it passes 5-0.

4. **Ordinance No. 05-2019** Adopting Changed Fines for Clackamas County for Fiscal Year 2019-2020 and Declaring an Emergency

Stephen Madkour, County Counsel presented the staff report.
~Board Discussion~
Chair Bernard opened the public hearing and asked if anyone wishes to speak, seeing none he closed the public hearing and asked for a motion to read by title only.

MOTION:
Commissioner Humberston: I move we read the Ordinance by title only.
Commissioner Schrader: Second.
all those in favor/opposed:
Commissioner Fischer: Aye.
Commissioner Humberston: Aye.
Commissioner Schrader: Aye.
Commissioner Savas: Aye.
Chair Bernard: Aye – it passes 5-0.

Chair Bernard asked the Clerk to assign a number and read the Ordinance by title only, then asked for a motion.

MOTION:
Commissioner Humberston: I move we adopt the Ordinance for the Changed Fines for Clackamas County Fiscal Year 2019-2020 and Declaring an Emergency
Commissioner Schrader: Second.
all those in favor/opposed:
Commissioner Fischer: Aye.
Commissioner Humberston: Aye.
Commissioner Schrader: Aye.
Commissioner Savas: Aye.
Chair Bernard: Aye – it passes 5-0.

The Board adjourned as the Clackamas County Board of Commissioners and convened as the Enhanced Law Enforcement District on the next item.

Enhanced Law Enforcement District

5. **Resolution No. 2019-64** Adopting the Enhanced Law Enforcement District Budget for the 2019-2020 Fiscal Year, Making Appropriations and Imposing and Categorizing Taxes for the Period of July 1, 2019 through June 30, 2020

Jennifer Chambers presented the staff report.

Chair Bernard opened the public hearing and asked if anyone wishes to speak, seeing none he closed the public hearing and asked for a motion.

MOTION:
Commissioner Humberston: I move we approve the action and adopt the 2019-2020 budget for the Clackamas County Enhanced Law Enforcement District as presented in the Resolution.
Commissioner Schrader: Second.
~Board Discussion~
all those in favor/opposed:
Commissioner Fischer: Aye.
Commissioner Humberston: Aye.
Commissioner Schrader: Aye.
Commissioner Savas: Aye.
Chair Bernard: Aye – it passes 5-0.

The Board adjourned as the Enhanced Law Enforcement District and convened as the Clackamas County Extension and 4-H Service District on the next item.

Clackamas County Extension & 4-H Service District

6. **Resolution No. 2019-65** Adopting the Clackamas County Extension & 4-H Service District Budget for the 2019-2020 Fiscal Year, Making Appropriations and Imposing and Categorizing Taxes for the Period of July 1, 2019 through June 30, 2020

Jennifer Chambers presented the staff report.
Chair Bernard opened the public hearing and asked if anyone wishes to speak, seeing none he closed the public hearing and asked for a motion.

MOTION:

Commissioner Schrader:	I move we approve the action and adopt the 2019-2020 budget for the Clackamas County Extension and 4-H Service District Budget as presented in the Resolution.
Commissioner Savas:	Second.

~Board Discussion~
all those in favor/opposed:

Commissioner Fischer:	Aye.
Commissioner Humberston:	Aye.
Commissioner Schrader:	Aye.
Commissioner Savas:	Aye.
Chair Bernard:	Aye – it passes 5-0.

The Board adjourned as the Extension and 4-H Service District and convened as the Library Service District of Clackamas County on the next item.

Library Service District of Clackamas County

7. **Resolution No. 2019-66** Adopting the Library Service District of Clackamas County 2019-2020 Fiscal Year Budget and Making Appropriations and Imposing and Categorizing Taxes for the Period of July 1, 2019 through June 30, 2020

Greg Williams, Business & Community Services presented the staff report.
Chair Bernard opened the public hearing and asked if anyone wishes to speak, seeing none he closed the public hearing and asked for a motion.

MOTION:

Commissioner Savas:	I move we approve the action and adopt the 2019-2020 budget for the Library Service District of Clackamas County as presented in the Resolution.
Commissioner Schrader:	Second.

all those in favor/opposed:

Commissioner Fischer:	Aye.
Commissioner Humberston:	Aye.
Commissioner Schrader:	Aye.
Commissioner Savas:	Aye.
Chair Bernard:	Aye – it passes 5-0.

The Board adjourned as the Library Service District of Clackamas County and convened as the North Clackamas Parks and Recreation District on the next item.

North Clackamas Parks & Recreation District

8. **Resolution No. 2019-67** Adopting the North Clackamas Parks & Recreation District's 2019-2020 Fiscal Year Budget and Making Appropriations and Imposing and Categorizing Taxes for the Period of July 1, 2019 through June 30, 2020

Scott Archer, North Clackamas Parks & Recreation District presented the staff report.
~Board Discussion~
Chair Bernard opened the public hearing and asked if anyone wishes to speak, seeing none he closed the public hearing and asked for a motion.

MOTION:

Commissioner Humberston: I move we approve the action and adopt the 2019-2020 budget for the North Clackamas Parks and Recreation District as presented in the Resolution.
Commissioner Savas: Second.
all those in favor/opposed:
Commissioner Fischer: Aye.
Commissioner Humberston: Aye.
Commissioner Schrader: Aye.
Commissioner Savas: Aye.
Chair Bernard: Aye – it passes 5-0.

The Board adjourned as the North Clackamas Parks and Recreation District and convened as the Development Agency on the next item.

Clackamas County Development Agency

9. **Resolution No. 2019-68** Adopting and Appropriating Funds for the 2019-2020 Fiscal Year Budget for the Clackamas County Development Agency

Dave Queener, Development Agency presented the staff report.
Chair Bernard opened the public hearing and asked if anyone wishes to speak, seeing none he closed the public hearing and asked for a motion.

MOTION:

Commissioner Savas: I move we approve the action and adopt the 2019-2020 budget for the Clackamas County Development Agency as presented in the Resolution.
Commissioner Humberston: Second.
all those in favor/opposed:
Commissioner Fischer: Aye.
Commissioner Humberston: Aye.
Commissioner Schrader: Aye.
Commissioner Savas: Aye.
Chair Bernard: Aye – it passes 5-0.

The Board adjourned as the Development Agency and convened as Service District No. 5 for the next item.

Service District No. 5, Street Lighting

10. **Resolution No. 2019-69** Adopting and Appropriating Funds for the 2019-2020 FY Budget for Clackamas County Service District No. 5

Wendi Coryell, Service District No. 5 presented the staff report.
~Board Discussion~
Chair Bernard opened the public hearing and asked if anyone wishes to speak, seeing none he closed the public hearing and asked for a motion.

MOTION:

Commissioner Humberston: I move we approve the action and adopt the 2019-2020 budget for Clackamas County Service District No. 5 as presented in the Resolution.
Commissioner Schrader: Second.
all those in favor/opposed:
Commissioner Fischer: Aye.
Commissioner Humberston: Aye.
Commissioner Schrader: Aye.
Commissioner Savas: Aye.
Chair Bernard: Aye – it passes 5-0.

The Board will adjourn as Service District No. 5 and convene as the Governing Body for Water Environment Services for the next three items.

Water Environment Services

11. **Resolution No. 2019-70** Adopting and Appropriating Funds for the 2019-2020 FY Budget for Water Environment Services

Greg Geist, Water Environment Services presented the staff report.
~Board Discussion~
Chair Bernard opened the public hearing and asked if anyone wishes to speak.

1. Tony Konkol, City of Oregon City, City Manager he is concern about Tri-City system development charges rate increase.

Greg Geist stated this is the first SDC increase since 2013.
~Board Discussion~ https://www.clackamas.us/meetings/bcc/business
Chair Bernard asked if anyone else would like to speak, seeing none he closed the public hearing and asked for a motion.

MOTION:

Commissioner Schrader:	I move we approve the action and adopt the 2019-2020 budget for Water Environment Services as presented in the Resolution.
Commissioner Savas:	Second.

~Board Discussion~
all those in favor/opposed:

Commissioner Fischer:	Aye.
Commissioner Humberston:	Aye.
Commissioner Schrader:	Aye.
Commissioner Savas:	No.
Chair Bernard:	Aye – it passes 4-1.

12. **Board Order No. 2019-71** Amending and Adopting Rates and Charges for Water Environment Services

Greg Geist, Water Environment Services presented the staff report.
Chair Bernard opened the public hearing and asked if anyone wishes to speak, seeing none he closed the public hearing and asked for a motion.

MOTION:

Commissioner Humberston:	I move we amend and adopt the rates and charges for Water Environment Services as presented in the Board Order.
Commissioner Schrader:	Second.

~Board Discussion~
all those in favor/opposed:

Commissioner Fischer:	Aye.
Commissioner Humberston:	Aye.
Commissioner Schrader:	Aye.
Commissioner Savas:	Aye.
Chair Bernard:	Aye – it passes 5-0.

13. **Board Order No. 2019-72** Establishing System Development Charges for Water Environment Services for Fiscal Year 2019-2020

Greg Geist, Water Environment Services presented the staff report.
Chair Bernard opened the public hearing and asked if anyone wishes to speak, seeing none he closed the public hearing and asked for a motion.

MOTION:

Commissioner Humberston:	I move we Establish System Development Charges for Water Environment Services for Fiscal Year 2019-2020 as presented in the Board Order.
Commissioner Schrader:	Second.
~Board Discussion~	
all those in favor/opposed:	
Commissioner Fischer:	Aye.
Commissioner Humberston:	Aye.
Commissioner Schrader:	Aye.
Commissioner Savas:	No.
Chair Bernard:	Aye – it passes 5-1.

The Board adjourned as Governing Body for Water Environment Services and re-convened as the Board of County Commissioners for the remainder of the meeting.

III. CONSENT AGENDA

Chair Bernard asked the Clerk to read the consent agenda by title, he then asked for a motion.

MOTION:

Commissioner Savas:	I move we approve the consent agenda.
Commissioner Schrader:	Second.
*~Board Discussion~*www.clackamas.us/meetings/bcc/business	
all those in favor/opposed:	
Commissioner Humberston:	Aye.
Commissioner Fischer:	Aye.
Commissioner Schrader:	Aye.
Commissioner Savas:	Aye.
Chair Bernard:	Aye – the Ayes have it, the motion passes 5-0.

A. Health, Housing & Human Services

1. Approval of an Amendment to the Intergovernmental Agreement with the City of Gladstone for the E. Clarendon Street Improvements Project – *Community Development*

2. Approval of a Subrecipient Grant Amendment with Community Living Above for Youth Marijuana and Substance Abuse Prevention Efforts in West Linn/Wilsonville – *Children, Youth & Community Connections*

3. Approval of a Subrecipient Grant Amendment with Northwest Family Services for PreventNet Community Schools – Urban, Milwaukie, Gladstone and Oregon City – *Children, Youth & Community Connections*

4. Approval of Local Grant Agreement with Northwest Family Services for Children of Incarcerated Parents (CIP) and Parenting Inside Out (PIO) Services – *Children, Youth & Community Connections*

5. Approval of a Subrecipient Grant Amendment with Northwest Family Services for Youth Marijuana and Substance Abuse Prevention Efforts in North Clackamas – *Children, Youth & Community Connections*

6. Approval of a Subrecipient Grant Amendment with Oregon Impact for Youth Marijuana and Substance Abuse Prevention Efforts in Clackamas County – *Children, Youth & Community Connections*

7. Approval of a Subrecipient Grant Amendment with Oregon City Together for Youth Marijuana and Substance Abuse Prevention Efforts in Clackamas County – *Children, Youth & Community Connections*

8. Approval of a Subrecipient Grant Amendment with Todos Juntos for Prevention and School Engagement Activities at PreventNet Sites in Clackamas County – *Children, Youth & Community Connections*

9. Approval of a Subrecipient Grant Amendment with Todos Juntos for Youth Marijuana and Substance Abuse Prevention Efforts in Rural Clackamas County – *Children, Youth & Community Connections*

10. Approval of a Subrecipient Agreement with the Tri-County Metropolitan Transportation District of Oregon (TriMet) for Disbursement of State of Oregon Special Transportation Improvement Funds for Public Transit Planning and Projects in Underserved Areas of Clackamas County – *Social Services*

11. Approval of a Subrecipient Agreement with Providence Health & Services, Regional Behavioral Health for Better Outcomes thru Bridges – *DHS Administration*

12. Approval of an Intergovernmental Agreement with the State of Oregon, acting by and through its Department of Human Services for Operation of Community Developmental Disability Services for Clackamas County – *Social Services*

B. Finance Department

1. **Resolution No. 2019-73** for a Clackamas County Supplemental Budget less than 10% or New Specific Purpose Revenue and Transfer of Appropriations for Fiscal Year 2018-2019

2. Approval of Lease for 16201 SE McLoughlin Boulevard with C. G. F. Family Limited Partnership for the Oak Lodge Library

3. Approval of Lease for the Homestead Building with Homestead Building, LLC for the Sandy Behavioral Health Center

4. Approval of Lease for the Willamette Building with Willamette Building Partnership

5. Approval of a FY 19/20 Work and Financial Plan with United State Department of Agriculture (USDA) Animal and Plant Health Inspection Service (APHIS), Wildlife Services (WS) for Predator Management

*6. **Resolution No. 2019-74** Acknowledging Expenditures in Excess of Appropriations and Financial Statement Findings for Fiscal Year 2018 and Describing Corrective Action in Accordance with *ORS 297.466*

C. Elected Officials

1. Approval of Previous Business Meeting Minutes – *BCC*

D. Juvenile Department

1. Approval of Intergovernmental Agreement with Multiple Cities for the Community Diversion Program Services

2. Approval of Personal Services Contract With Maple Star Oregon, Inc. to provide Short Term Residential Placement Services – *Procurement*

3. Approval of Personal Services Contract With The Boys and Girls Society of Oregon to provide Short Term Residential Placement Services – *Procurement*

E. Human Resources

1. Approval of Contract Renewal between the Clackamas County Department of Human Resources and Mercer Health & Benefits LLC to provide Benefits Consulting Services – *Procurement*

F. County Administration

1. Approval of an Amendment to an Intergovernmental Agreements with the State of Oregon Related to Funding for a Future County Courthouse

G. Disaster Management

1. Approval of FY18 Urban Area Security Initiative (UASI) Subrecipient Grant Agreement with the City of Oregon City

H. County Counsel

1. Approval of Designation of Newspaper for the 2019 Property Tax Foreclosure Publication

I. Tourism & Cultural Affairs

1. Approval of the Contract Amendment No. 3 with Borders Perrin Norrander for Marketing Agency of Record Services for the Tourism & Cultural Affairs Department – *Procurement*

J. Technology Services

1. Approval of an ORMAP Intergovernmental Agreement Contract No. DOR-189-19 between Clackamas County and the Oregon Department of Revenue for Digital GIS Tax Lot Conversion

IV. NORTH CLACKAMAS PARKS & RECREATION DISTRICT

1. **Resolution No. 2019-75** Accepting a Pathway Easement from Cereghino Farms, LLC

V. COUNTY ADMINISTRATOR UPDATE
www.clackamas.us/meetings/bcc/business

VI. COMMISSIONERS COMMUNICATION
www.clackamas.us/meetings/bcc/business

MEETING ADJOURNED – 12:26 PM

BOARD OF COUNTY COMMISSIONERS BUSINESS MEETING MINUTES

A complete video copy and packet including staff reports of this meeting can be viewed at http://www.clackamas.us/bcc/business.html

Thursday, July 11, 2019 – 10:00 AM
Public Services Building
2051 Kaen Rd., Oregon City, OR 97045

PRESENT: **Commissioner Sonya Fischer, Serving as Chair**
Commissioner Ken Humberston
Commissioner Martha Schrader
EXCUSED: **Commissioner Jim Bernard, Chair**
Commissioner Paul Savas

CALL TO ORDER

- Roll Call

Chair Bernard and Commissioner Savas are out of the office and will not be in attendance today, Commissioner Fischer will serve as Chair for this meeting.

- Pledge of Allegiance

I. CITIZEN COMMUNICATION

https://www.clackamas.us/meetings/bcc/business

1. Les Poole, Gladstone – transportation issues and issues in Salem.
2. Brainard Brauer, Oregon City – road safety in Redland, asking when radar signs will be installed and who will determine the placement.
3. Bill Wehr, Damascus – Damascus issues.
4. James DeYoung, Damascus – Damascus issues.

II. PUBLIC HEARING

1. Second Reading of Ordinance No. 04-2019 Amending Chapter 10.03, Solid Waste and Wastes Management, of the Clackamas County Code Adopting A Food Waste Collection Requirement for Certain Businesses - *first reading was 6-13-19*

Stephen Madkour, County Counsel presented the staff report.
Chair Fischer opened the public hearing and asked if anyone wishes to speak, seeing none she asked for a motion.

MOTION:
Commissioner Schrader: I move we read the Ordinance by title only.
Commissioner Humberston: Second.
all those in favor/opposed:
Commissioner Humberston: Aye.
Commissioner Schrader: Aye.
Chair Fischer: Aye – the Ayes have it, the motion carries 3-0.

Chair Fischer asked the Clerk read the Ordinance by title only, then asked for a motion to adopt.

MOTION:
Commissioner Humberston. I move we adopt Ordinance No. 04-2019 Amending chapter 10.03, Solid Waste and Waste Management, of the Clackamas County Code Adopting a food waste collection requirement for certain businesses.
Commissioner Schrader: Second.
all those in favor/opposed:
Commissioner Humberston: Aye.
Commissioner Schrader: Aye.
Chair Fischer: Aye – the Ayes have it, the motion carries 3-0.

The Board will recess as the Board of County Commissioners and convene as the Board of Health for the next items.

III. BOARD OF HEALTH

Dr. Sarah Present, Clackamas County Public Health introduced the following two presentations.

BOARD OF HEALTH PRESENTATIONS

(Following are items of interest to the citizens of the County)

1. Reaffirming the Transportation Safety Action Plan

Abe Moland, Public Health, Joe Marek, Department to Transportation & Development presented the staff report including a PowerPoint presentation.

~Board Discussion~

Chair Fischer asked for a motion.

MOTION:

Commissioner Humberston:	I move we reaffirm our approval of the Transportation Safety Action plan as it relates to Public Health.
Commissioner Schrader:	Second.
all those in favor/opposed:	
Commissioner Humberston:	Aye.
Commissioner Schrader:	Aye.
Chair Fischer:	Aye – the Ayes have it, the motion carries 3-0.

2. Presentation of the Blueprint for a Healthy Clackamas County

Phillip Mason-Joyner presented the staff report including a PowerPoint presentation.

BOARD OF HEALTH PUBLIC COMMENT

https://www.clackamas.us/meetings/bcc/business

1. Karen Saxe, Oregon City, Representing NEDCO and Willamette Neighborhood Housing Services – spoke in support of the blueprint for a healthy Clackamas County.
2. Eric Johnston, Canby, Representing Todos Juntos – spoke in support of the blueprint for a healthy Clackamas County.

The Board Adjourned as the Board of Health Reconvene as the Board of County Commissioners for the remainder of the meeting.

IV. CONSENT AGENDA

Chair Fischer asked the Clerk to read the consent agenda by title, then asked for a motion.

~Board Discussion~

MOTION:

Commissioner Humberston:	I move we approve the consent agenda.
Commissioner Schrader:	Second.
all those in favor/opposed:	
Commissioner Humberston:	Aye.
Commissioner Schrader:	Aye.
Chair Fischer:	Aye – the Ayes have it, the motion carries 3-0.

A. Health, Housing & Human Services

1. Approval of Sub-recipient Professional Services Agreement with Outside In, Inc. for HIV Testing and Counseling Services – *Public Health*

2. Approval of Intergovernmental Grant Agreement with Oregon Health & Science University for the Oregon Care Coordination Program (CaCoon) – *Public Health*

3. Approval of Intergovernmental Agreement No.159475 with the State of Oregon, Department of Human Services, Aging and People with Disabilities Division for the Provision of the Oregon Money Management Program in Clackamas County – *Social Services*

4. Approval of Professional Services Agreement No. 8345, Amendment No. 4 with Mt. Hood Home Care Services, LLC to provide Oregon Project Independence In-home care for Clackamas County Residents – *Social Services*

5. Approval of Intergovernmental Agreement No. 160453 with the State of Oregon, Department of Human Services, Aging and People with Disabilities Division for the Provision of No Wrong Door Services to Clackamas County Residents – *Social Services*

6. Approval of Intergovernmental Agreement No. 154433, Amendment No. 4 with the State of Oregon, Department of Human Services, Aging and People with Disabilities Division for the Provision of Services to Clackamas County Older Adult Residents – *Social Services*

7. Approval of Agreements Nos.18575, 18576 and 18577, Modification No. 1 with Ride Connection, Inc. to Provide Funding for Rides Provided by Social Services, Transportation Reaching People – *Social Services*

8. Approval of Agreement No. 18574, Modification 1 with Ride Connection, Inc. to Provide Funding for Rides Provided by Members of the Clackamas County Transportation Consortium – *Social Services*

9. Approval of Agreement No. 18573, Modification 1, with Ride Connection, Inc. to Provide Funding for Specialized Service Rides Provided by Members of the Clackamas County Transportation Consortium – *Social Services*

10. Approval of Agreement with Oregon Department of Transportation, Rail and Public Transit Division, for 5310 Enhanced Mobility Funds for Preventative Maintenance, Operations and Replacement Vehicle Funding for Mt Hood Express and Transportation Reaching People and Transportation Services to Boring – *Social Services*

B. <u>Department of Transportation & Development</u>

1. Approval of a Federal Lands Access Program Project Memorandum of Agreement with Western Federal Lands Highway Division for the Lolo Pass Road Stabilization and Surface Preservation Project

2. Approval of a Federal Lands Access Program Project Memorandum of Agreement with Western Federal Lands Highway Division for the East Salmon River Road Surface Preservation Project

3. Approval of a Contract with the National Safety Council for the Purposes of Safe Systems Approach to Rural Road to Zero

4. Approval to Apply for a BUILD Discretionary Transportation Grant to Replace the Bridge Across the Bull Run River

5. Approval of Contract with Pioneer Truckweld, Inc. to Retrofit the Hydraulic System for the New Plow System - *Procurement*

C. <u>Finance Department</u>

1. **Resolution No. 2019-76** to Create a Class Special Procurement Process for the 340B Third Party Administration Claims Management of Pharmacy Services – *Procurement for H3S*

D. Elected Officials

1. Request by the Clackamas County Sheriff's Office to Apply for a Grant with Clackamas Women's Services and the Family Justice Center Services via New Pathways of Hope and Healing for Polyvictims - *CCSO*

E. County Counsel

1. **Board Order No. 2019-77** Related to a Previously Approved Zone Change Application, Removal of Historic Landmark Designation (Z0067-19)

F. Business & Community Services

1. Approval of an Allocation Certification Agreement with the Oregon State Marine Board for Maintenance Assistance Program (MAP 2019-20 Funding

G. Technology Services

1. Approval for a Service Level Agreement with North Clackamas Park and Recreation District for the Lease of Dark Fiber Connection

H. Juvenile Department

1. Approval of Intergovernmental Agreement with the State of Oregon Acting by and through its Oregon Department of Education, Youth Development Division for the Community Diversion Program

2. Approval of Amendment No. 4 to the Intergovernmental Agreement No. 931488 with Metro for Litter Pick-up near the Metro South Transfer Station

3. Approval of an Intergovernmental Agreement with Clackamas Education Service District to Provide Education and Vocational Opportunities for At-Risk Youth

I. Community Corrections

1. Approval of an Intergovernmental Agreement between Clackamas County Community Corrections and Clackamas River Water to Provide Work Crew Services for Fiscal Year 2019-2020.

2. Approval of an Intergovernmental Agreement between Clackamas County Community Corrections and City of Wilsonville to Provide Work Crew Services for Fiscal Year 2019-2020.

3. Approval of an Intergovernmental Agreement between Clackamas County Community Corrections and Clackamas County Fair Board to Provide Work Crew Services for Fiscal Year 2019-2020.

4. Approval of an Intergovernmental Agreement between Clackamas County Community Corrections and Clackamas Community College to Provide Work Crew Services for Fiscal Year 2019-2020.

V. NORTH CLACKAMAS PARKS & RECREATION DISTRICT

1. Approval of an Interagency Agreement between North Clackamas Parks & Recreation District, Milwaukie Center and Health, Housing, & Human Services for Social Services Programs

2. Approval of a Grant Agreement with the Oregon State Marine Board (OSMB) as Part of the Maintenance Assistance Program (MAP) for FY 2019-20

3. Approval of a Service Level Agreement with Clackamas Broadband Exchange for the Lease of Dark Fiber Connection

4. Approval of an Intergovernmental Agreement with Clackamas Education Service District (CESD) for Internet Service

VI. WATER ENVIRONMENT SERVICES

1. Approval of an Intergovernmental Agreement between Portland State University and Water Environment Services for Water Quality Model Updates

2. Approval of a Public Contract between Water Environment Services and Lucity, Inc. for Constant Connection program Annual Support and Maintenance *- Procurement*

VII. COUNTY ADMINISTRATOR UPDATE

https://www.clackamas.us/meetings/bcc/business

VIII. COMMISSIONERS COMMUNICATION

https://www.clackamas.us/meetings/bcc/business

MEETING ADJOURNED – 11:26 AM

NOTE: ***Regularly scheduled Business Meetings are televised and broadcast on the Clackamas County Government Channel. These programs are also accessible through the County's Internet site. DVD copies of regularly scheduled BCC Thursday Business Meetings are available for checkout at the Clackamas County Library in Oak Grove. You may also order copies from any library in Clackamas County or the Clackamas County Government Channel.*** https://www.clackamas.us/meetings/bcc/business

BOARD OF COUNTY COMMISSIONERS BUSINESS MEETING MINUTES

A complete video copy and packet including staff reports of this meeting can be viewed at https://www.clackamas.us/meetings/bcc/business

Thursday, July 18, 2019 – 10:00 AM
Public Services Building
2051 Kaen Rd., Oregon City, OR 97045

PRESENT: **Commissioner Jim Bernard. Chair**
Commissioner Ken Humberston
Commissioner Paul Savas
Commissioner Martha Schrader
Commissioner Sonya Fischer
Housing Authority Commissioner Paul Reynolds

CALL TO ORDER

- Roll Call
- Pledge of Allegiance

Chair Bernard announced the Board will recess as the Board of County Commissioners and convene as the Housing Authority Board for the next item, he introduced Housing Authority Commissioner Paul Reynolds.

I. HOUSING AUTHORITY CONSENT AGENDA

Chair Bernard asked the Clerk to read the Housing Authority consent agenda by title, then asked for a motion.

MOTION:

Commissioner Reynolds:	I move we approve the Housing Authority consent agenda.
Commissioner Humberston:	Second.
all those in favor/opposed:	
Commissioner Reynolds:	Aye.
Commissioner Humberston:	Aye.
Commissioner Schrader:	Aye.
Commissioner Savas:	Aye.
Commissioner Fischer	Aye.
Chair Bernard:	Aye – the Ayes have it, the motion carries 6-0.

1. In the Matter of Approving Delegation of Budget Authority for Fiscal Year 2019-2020

2. Approval to Execute a Contract between the Housing Authority of Clackamas County and Greater Purpose Construction, LLC to Replace Roofing on Twenty-Four Public Housing Properties

Chair Bernard announced the Board would adjourn as the Housing Authority Board and Reconvene as the Board of County Commissioners for the remainder of the meeting.

II. PRESENTATION *(Following are items of interest to the citizens of the County)*

1. National Association of Counties (NACo) 2019 Achievement Awards

Ed Nieto, Public & Government Affairs presented the staff report. Clackamas County won 4 NACo Achievement awards this year. He introduced Mary Rumba, H3S, Vahid Brown, H3S, Shelly Parini, WES and Ron Wierenga, WES who spoke about each award.

1. H3S: Senior Loneliness Line.
2. Multiple Departments: Veterans Village, a Transitional Shelter Community of Veterans.
3. WES: Serving a Growing Population, Solids Handling Capacity Improvement Project.
4. WES: Carli Creek Water Quality Project.

The Board thanked everyone involved for their work for these achievement awards.

III. CITIZEN COMMUNICATION

https://www.clackamas.us/meetings/bcc/business

1. Gail Yazzolino, Oregon City –Clackamas County History Hub – spoke in support of Clackamas County Heritage.
2. James DeYoung, Damascus – Damascus issue.
3. Chris Previti, Beavercreek – Representing Northwest Bible Training Center – wanted to introduce and talk about the Training Center.

IV. PUBLIC HEARINGS

1. **Board Order No. 2019-78** for Boundary Change Proposal CL 18-012 Annexation to Clackamas County Service District No. 1

Ken Martin, Boundary Change Consultant presented the staff report.
Chair Bernard opened the public hearing and asked if anyone would like to speak, seeing none he closed the public hearing and asked for a motion.

MOTION:

Commissioner Humberston:	I move we approve the Board Order for Boundary Change Proposal CL 18-012 Annexation to Clackamas County Service District No. 1.
Commissioner Savas:	Second.
all those in favor/opposed:	
Commissioner Humberston:	Aye.
Commissioner Fischer:	Aye.
Commissioner Savas:	Aye.
Commissioner Schrader	Aye.
Chair Bernard:	Aye – the Ayes have it, the motion carries 5-0.

2. **Board Order No. 2019-79** for Boundary Change Proposal CL 19-003 Annexation to Tri-City Service District

Ken Martin, Boundary Change Consultant presented the staff report.
Chair Bernard opened the public hearing and asked if anyone would like to speak, seeing none he closed the public hearing and asked for a motion.

MOTION:

Commissioner Humberston:	I move we approve the Board Order for Boundary Change Proposal CL 19-003 Annexation to Tri-City Service District.
Commissioner Savas:	Second.
all those in favor/opposed:	
Commissioner Humberston:	Aye.
Commissioner Fischer:	Aye.
Commissioner Savas:	Aye.
Commissioner Schrader	Aye.
Chair Bernard:	Aye – the Ayes have it, the motion carries 5-0.

3. First Reading of **Ordinance No. 06-2019** Amending Chapter 8 (Business Regulation), Section 8.07, Alarm Systems of the Clackamas County Code

Julie Rush, Clackamas County Sheriff's Office presented the staff report.
~Board Discussion~
Chair Bernard opened the public hearing and asked if anyone would like to speak, seeing none he closed the public hearing and asked for a motion.

MOTION:

Commissioner Schrader:	I move we read the Ordinance by title only.
Commissioner Humberston:	Second.
all those in favor/opposed:	

Commissioner Fischer: Aye.
Commissioner Humberston: Aye.
Commissioner Savas: Aye.
Commissioner Schrader: Aye.
Chair Bernard: Aye – the Ayes have it, the motion carries 5-0.
The Clerk assigned **Ordinance No. 06-2019** and read the ordinance by title only.
Chair Bernard announced the second reading will be on Thursday, August 8, 2019 at our regular scheduled Business meeting at 10 AM.

V. CONSENT AGENDA

Chair Bernard asked the Clerk to read the consent agenda by title, then asked for a motion.
MOTION:
Commissioner Humberston: I move we approve the consent agenda.
Commissioner Savas: Second.
~Board Discussion~
all those in favor/opposed:
Commissioner Humberston: Aye.
Commissioner Schrader: Aye.
Commissioner Savas: Aye.
Commissioner Fischer Aye.
Chair Bernard: Aye – the Ayes have it, the motion carries 5-0.

A. Health, Housing & Human Services

1. Approval of Amendment No. 1 to the Intergovernmental Agreement #HD-ICA-E-690-2018 with Multnomah County, for the Human Immunodeficiency Virus (HIV) Early Intervention and Outreach (EIO) Project – *Public Health*

2. Approval of Intergovernmental Agreement with the City of Lake Oswego for providing Medical Direction for the Lake Oswego Fire Department and Communications Center – *Public Health*

3. Approval of an Intergovernmental Agreement with the Housing Authority of Clackamas County and the Community Development Division for the Arbor Terrace Apartments Roofing Project – *Community Development*

4. Approval of an Intergovernmental Revenue Agreement Amendment No. 1 with Oregon Health Authority for Drug and Alcohol Prevention Education and Programming – *Children, Families & Community Connections*

5. Approval of a Revenue Contract for Professional Service with Oregon State University for Evidence-based Parenting Education Classes – *Children, Families & Community Connections*

6. Approval of Intergovernmental Agreement No. 16044-0 with the State of Oregon, Department of Human Services, Aging and People with Disabilities Division for the Provision of Services to Clackamas County Residents – *Social Services*

7. Approval of Agreement with Oregon Department of Transportation, Rail and Public Transit Division, for FTA 5311 Rural Transportation Funds for Operations of Mt Hood Express – *Social Services*

8. Approval of an Intergovernmental Agreement with City of Sandy, Oregon, for Operations for the Mt Hood Express Bus Service – *Social Services*

B. Department of Transportation & Development

1. Approval of a Contract with DKS Associates, Inc., to Provide All Roads Transportation Safety Program - *Procurement*

C. Elected Officials

1. Approval of Previous Business Meeting Minutes – *BCC*
2. Approval of ORMAP Intergovernmental Agreement Contract No. DOR-190-19 between Clackamas County Assessor's Office and the Oregon Department of Revenue for the Administration of the Ad Valorem Property Tax System - *Assessor*

D. County Counsel

1. Approval of a Memorandum of Understanding with Mount Hood Search and Rescue Council for Equipment Storage

E. Business & Community Services

1. Approval of an Intergovernmental Agreement Amendment with the City of Gladstone to Provided Library Director Services
2. Approval of Boating Facility Grant Intergovernmental Agreement No. 1634 for Resurfaced Parking, Replace Curbing and Sidewalks and Restripe Parking Area at Carver Park

VI. NORTH CLACKAMAS PARKS & RECREATION DISTRICT

1. Approval of an Intergovernmental Agreement with Clackamas Community College for Educational & Enrichment Services
2. Approval of an Intergovernmental Agreement with Clackamas Community College for Based Instructional Programs

VII. COUNTY ADMINISTRATOR UPDATE
https://www.clackamas.us/meetings/bcc/business

VIII. COMMISSIONERS COMMUNICATION
https://www.clackamas.us/meetings/bcc/business

MEETING ADJOURNED – 11:22 AM

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BOARD OF COUNTY COMMISSIONERS BUSINESS MEETING MINUTES

A complete video copy and packet including staff reports of this meeting can be viewed at https://www.clackamas.us/meetings/bcc/business

Thursday, July 25, 2019 – 10:00 AM
Public Services Building
2051 Kaen Rd., Oregon City, OR 97045

PRESENT: **Commissioner Jim Bernard. Chair**
Commissioner Ken Humberston
Commissioner Paul Savas
Commissioner Sonya Fischer
EXCUSED: **Commissioner Martha Schrader**

CALL TO ORDER

- Roll Call
- Pledge of Allegiance

I. CITIZEN COMMUNICATION

https://www.clackamas.us/meetings/bcc/business

1. Michelle DaRosa, Milwaukie – condominium plat issue.

County Counsel stated this is an emerging matter and they are working on this issue.

2. Lisa Bentley, Milwaukie – spoke in support of the Clackamas County Heritage Council and the preserving the history of our County.
3. Bill Wehr, Damascus – support of recognizing Damascus as a city.
4. Richard Johnson, Damascus – supports recognizing Damascus as a city.
5. Douglas Walker, Damascus – supports Mayor of Damascus.
6. James DeYoung, Damascus – representing the City of Damascus.

~Board Discussion~ regarding Damascus.

7. Les Poole, Gladstone – County Fair, Tolling issue, unjust attacks by the Chair.

II. CONSENT AGENDA

Chair Bernard asked the Clerk to read the consent agenda by title, then asked for a motion.
~Board Discussion~

MOTION:

Commissioner Humberston:	I move we approve the consent agenda.
Commissioner Fischer:	Second.
all those in favor/opposed:	
Commissioner Humberston:	Aye.
Commissioner Savas:	Aye.
Commissioner Fischer	Aye.
Chair Bernard:	Aye – the Ayes have it, the motion carries 4-0.

A. Health, Housing & Human Services

1. Approval to Apply for a Grant from Oregon Department of Education Youth Development Division for Youth and Community to Fund PreventNet Community School Sites in Clackamas County – *Children, Families & Community Connections*

2. Approval of a Revenue Grant Agreement with Health Share of Oregon for Help me Grow Liaisons – *Children, Families & Community Connections*

3. Approval of a Local Grant Agreement with Northwest Family Services to Provide Evidence-based parenting Education Classes - – *Children, Families & Community Connections*

4. Approval of a Local Grant Agreement with Todos Juntos to Provide Evidence-based parting Education Classes - – *Children, Families & Community Connections*

5. Approval of an Intergovernmental Agreement with North Clackamas Parks and Recreation District, Milwaukie Center to Provide Social Services for Clackamas County Residents – *Social Services*

6. Approval of a Subrecipient Agreement with Legal Aid Services of Oregon to Provide Housing Rights and Referral and Legal assistance for Clackamas County Residents – *Social Services*

B. Department of Transportation & Development

1. Approval of Intergovernmental Agreement between Clackamas County and the City of Molalla Related to Plan Review, Permitting, and Inspection Services

2. Approval of a Contract with Harper Houf Peterson Righellis, Inc. for the Canby Ferry ITS Project - *Procurement*

C. Elected Officials

1. Request by the Clackamas County Sheriff's Office to Approve an Intergovernmental Agreement with Oregon Department of Transportation for the Oregon Motor Carrier Safety Action Plan - *CCSO*

D. Business & Community Services

1. Approval of Grant Modification No. 2 between Clackamas County and USDA Forest Service – Mt. Hood National Forest for the Dump Stoppers Program

E. Tourism & Cultural Affairs

1. Approval of a Personal/Professional Services Contract with Travel Portland for the Portland Region Partner Agreement - Regional Cooperative Tourism Program (RCTP)

2. Approval of a Personal/Professional Services Contract with Oregon Tourism Commission for the Mt. Hood/Columbia River Gorge Region Partner Agreement - Regional Cooperative Tourism Program (RCTP)

F. Technology Services

1. Approval of a Service Level Agreement with Clackamas Soil and Water Conservation District for Lease of Dark Fiber Connections

2. Approval of a Service Level Agreement with Harmony Academy for the Lease of Dark Fiber Connection

III. COUNTY ADMINISTRATOR UPDATE
https://www.clackamas.us/meetings/bcc/business

IV. COMMISSIONERS COMMUNICATION
https://www.clackamas.us/meetings/bcc/business

MEETING ADJOURNED – 11:13 AM

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Clackamas County Sheriff's Office

CRAIG ROBERTS, Sheriff

September 5, 2019

Board of County Commissioners
Clackamas County

Members of the Board:

Request by the Clackamas County Sheriff's Office to enter into the Annual Operating and Financial Plan with the USDA Forest Service for
Cooperative Law Enforcement Services in the Mt. Hood National Forest

Purpose/Outcome	The Sheriff's Office will provide patrol services in the Mt. Hood National Forest during the summer months of May through September or at other times as funding permits.
Dollar Amount and Fiscal Impact	The total calendar year 2019 operating plan is $69,212.45. Law enforcement activities will be billed by the hour.
Funding Source	The USDA, Forest Service is the source of funds for this agreement as billed by the Clackamas County Sheriff's Office.
Safety Impact	The funds will provide patrol services in the Mt. Hood National Forest for general patrol. The assigned Deputies would also be available for other support and assistance as requested by the U.S. Forest Service.
Duration	Effective upon signature and terminates on December 31, 2019.
Previous Board Action/Review	Agreement has been approved annually since FY 2013.
Contact Person	Nancy Artmann, Sheriff's Finance Manager – Office (503) 785-5012
Contract No.	FS Agreement No. 18-LE-11060600-007

BACKGROUND:
The Sheriff's Office provides patrol coverage annually to the U.S. Forest Service for patrols on Forest Service land. This coverage is primarily between Memorial Day and Labor Day when the public is more active in the area. Two deputies are assigned including one on National Forest System lands within the Zigzag Ranger District and one within the Clackamas River Ranger District and includes patrols in campgrounds, developed sites and dispersed areas.

This contract reimburses the Sheriff's Office for the cost of the deputies as well as associated support costs including vehicles and supervision. The agreement has been reviewed and approved by County Counsel.

RECOMMENDATION:
Staff recommends the Board approve this cooperative agreement and authorizes Craig Roberts, Sheriff to sign on behalf of Clackamas County.

Respectfully submitted,

Craig Roberts

Craig Roberts,
Sheriff

FS Agreement No. 18-LE-11060600-007
Cooperator Agreement No. _____

EXHIBIT A

COOPERATIVE LAW ENFORCEMENT ANNUAL OPERATING PLAN & FINANCIAL PLAN
Between
COUNTY OF CLACKAMAS
CLACKAMAS COUNTY SHERIFF'S DEPARTMENT
and the
USDA, FOREST SERVICE
MT. HOOD NATIONAL FOREST

2019 ANNUAL OPERATING AND FINANCIAL PLAN

This Annual Financial and Operating Plan (Annual Operating Plan), is hereby made and entered into by and between County of Clackamas, Clackamas County Sheriff's Department, hereinafter referred to as "Cooperator," and the USDA, Forest Service, Mt. Hood National Forest, hereinafter referred to as the "U.S. Forest Service," under the provisions of Cooperative Law Enforcement Agreement #18-LE-11060600-007 executed on date of last signature. This Annual Operating Plan is made and agreed to as of the last date signed below and is for the estimated period beginning January 1, 2019 and ending December 31, 2019.

Previous Year Carry-over: $41,239.45
Current Calendar Year Obligation: $29,973.00
CY2019 Total Annual Operating Plan: $69,212.45

I. GENERAL:

A. The following individuals shall be the designated and alternate representative(s) of each party, so designated to make or receive requests for special enforcement activities.

Principal Cooperator Contacts:

Cooperator Program Contact	Cooperator Administrative Contact
Lt. Graham Phalen 2223 Kaen Road Oregon City, OR 97045 Telephone: 503-785-5117 FAX: 503-785-5190 Email: grahampha@co.clackamas.or.us	Nancy Artmann 9101 SE Sunnybrook Blvd Clackamas, OR 97015 Telephone: 503-785-5012 FAX: 503-785-5027 Email: nartmann@co.clackamas.or.us

Principal U.S. Forest Service Contacts:

U.S. Forest Service Program Manager Contact	U.S. Forest Service Administrative Contact
Andy Coriell 16400 Champion Way Sandy, OR 97055 Telephone: 503-668-1789 FAX: 503-668-1738 Email: acoriell@fs.fed.us	Rachele Avery 16400 Champion Way Sandy, OR 97055 Telephone: 503-668-1625 FAX: 503-668-1771 Email: racheleavery@fs.fed.us

B. Reimbursement for all types of enforcement activities shall be at the following rates unless specifically stated otherwise:

Wages at the prevailing rate of $79.62 per hour and overtime at the rate of $97.45 per hour.

II. PATROL ACTIVITIES:

A. Time schedules for patrols will be flexible to allow for emergencies, other priorities, and day-to-day needs of both the Cooperator and the U.S. Forest Service. Ample time will be spent in each area to make residents and visitors aware that law enforcement officers are in the vicinity.

Timely reports and/or information relating to incidents or crimes that have occurred on National Forest System lands should be provided to the U.S. Forest Service as soon as possible.

The primary patrol activities will be during the summer months of May through September; the tour of duty will be ten hours per day on Friday, Saturday and Sunday, and include the national holidays of May 27, 2019, July 4, 2019 and September 2, 2019. Patrol activities may also occur during other months, as funding permits and as agreed to between the Cooperator and U.S. Forest Service. Patrol dates may be varied to address operational needs after mutual agreement between the Cooperator's and the U.S. Forest Service's representatives.

Each tour of duty should begin between 12:00 PM and 4:00 PM and remaining work hours may be varied as agreed to between the Cooperator and U.S. Forest Service.

The assigned Deputies will check in, as practical with the Ranger District Office or U.S. Forest Service Law Enforcement Officer when they begin their tour of duty, in person, by radio or telephone.

During scheduled vacations the cooperator, when possible, provide fill in Deputies for patrol.

The assigned Deputies would be available for other support and assistance as requested by the U.S. Forest Service.

There are patrol related activities, which will impact the Cooperating Deputy's time and will cause them to be away from the patrol route (court, reports, or responding to incidents off National Forest). No adjustment to this plan will be required so long as the activities are held to, not more than 5 percent of the Deputy's scheduled time.

1. Patrol on following U.S. Forest Service roads:

   One Deputy will be assigned to National Forest System lands within the Zigzag Ranger District. The patrol will begin near Zigzag, Oregon and will include National Forest lands north and south of State Hwy. 26 and east of the Forest boundary to Timothy Lake.

   One Deputy will be assigned to National Forest System lands within the Clackamas River Ranger District. The patrol will begin near Estacada, Oregon and will include National Forest lands north and south of Hwy. 224 and east of the Forest boundary, and lands adjacent to U.S. Forest Service Roads 46, 63 and 70.

2. Patrol in the following campgrounds, developed sites, and dispersed areas:

   Zigzag Ranger District:
   Burnt Lake and Ramona Falls Trailheads, and all dispersed campsites.
   Timothy Lake, and all lands and roads adjacent to Timothy Lake.
   Trillium Lake, and all lands and roads adjacent to Trillium Lake.
   Dispersed recreation along U.S. Forest Service Road 5750 and 5750-220 south of Gone Creek Campground.

   Clackamas River Ranger District:
   Timber Lake Job Corps Center
   Dispersed recreation areas east of Promontory Park on Hwy. 224
   Dispersed recreation areas east of Hwy. 224 via U.S. Forest Service Road 57 and 4630.
   Dispersed recreation areas via U.S. Forest Service Roads 46, 63 and 70. (Bagby Hot Springs Recreational Area)

Patrol routes may be varied at the discretion of the assigned Deputies in order to effectively deal with incidents at other locations as they occur.

Search and rescue within the Mt Hood National Forest, within Clackamas County, is the responsibility of the Clackamas County Sheriff. The role of the assigned Deputies to this

agreement is to take initial action on search and rescue incidents and to coordinate subsequent (short term) activities.

Total reimbursement for this category shall not exceed the amount of **$27,973.00**.

III. EQUIPMENT:

See Cooperative Law Enforcement Agreement Provisions IV-K, IV-L, and IV-M for additional information.

A. The U.S. Forest Service agrees to reimburse Clackamas County for equipment and supplies in an amount not to exceed $1,000. All purchases must be approved by the U.S. Forest Service prior to purchase. Documentation of such purchases shall become part of the Cooperative Agreements' official file.

B. The U.S. Forest Service may loan Clackamas County equipment as needed, when mutually agreed. While in possession of Clackamas County, maintenance of this equipment shall be the responsibility of the Cooperator and shall be returned in same condition as time of transfer

Total reimbursement for this category will be paid out of the Patrol Activity funds in Section II.

IV. SPECIAL ENFORCEMENT SITUATIONS:

A. Special Enforcement Situations include but are not limited to: Fire Emergencies, Drug Enforcement, and certain Group Gatherings.

B. Funds available for special enforcement situations vary greatly from year to year and must be specifically requested and approved prior to any reimbursement being authorized. Requests for funds should be made to the U.S. Forest Service designated representative listed in Item I-A of this Annual Operating Plan. The designated representative will then notify the Cooperator whether funds will be authorized for reimbursement. If funds are authorized, the parties will then jointly prepare a revised Annual Operating Plan.

1. Drug Enforcement: This will be handled on a case by case basis. The request will normally come from the Patrol Captain; however, it may come from the Special Agent in Charge or their designated representative. Reimbursement shall be made at the rates specified in Section I-B. Deputies assigned to the incident will coordinate all of their activities with the designated officer in charge of the incident.

   Authorized activities associated with Drug Enforcement will be identified separately on billings supplied by the Cooperator.

2. Fire Emergency: During emergency fire suppression situations and upon request by the U.S. Forest Service pursuant to an incident resource order, the Cooperator agrees to provide special services beyond those provided under Section II-A, within the Cooperator's resource capabilities, for the enforcement of State and local laws related to the protection of persons and their property. The Cooperator will be compensated at the rate specified in Section I-B; the U.S. Forest Service will specify times and schedules. Upon concurrence of the local Patrol Captain or their designated representative, an official from the Incident Management Team managing the incident, Cooperator personnel assigned to an incident where meals are provided will be entitled to such meals.

3. Group Gatherings: This includes but is not limited to situations which are normally unanticipated or which typically include very short notices, large group gatherings such as rock concerts, demonstrations, and organization rendezvous.

   Upon authorization by a U.S. Forest Service representative listed in Section I-A for requested services of this nature, reimbursement shall be made at the rates specified in Section I-B. Deputies assigned to this type of incident will normally coordinate their activities with the designated officer in charge of the incident.

C. Billing Documentation:

The billing for each incident shall include individual employee times and their agreement rate. Such times will be documented on Crew Time Reports, shift tickets or other agreed upon form, and must be approved by incident management personnel.

For billing done using procedures specified in Section V-B-2, original documentation will be maintained by the U.S. Forest Service in the appropriate fire documentation boxes or appropriate incident management personnel; the Cooperator will maintain copies of all such documentation.

V. BILLING FREQUENCY:

See Cooperative Law Enforcement Agreement Provisions II-H and III-B for additional information.

A. The Cooperator will submit invoices for reimbursement of services provided under Section II of this agreement monthly or quarterly, at the discretion of the Cooperator.

USDA Forest Service
Albuquerque Service Center
Payments-Grants and Agreements
101B Sun Ave NE
Albuquerque, NM 87109
FAX: 1-877-687-4894
E-Mail: asc_ga@fs.fed.us

The Cooperator will prepare an itemized statement for each invoice submitted to the Albuquerque Service Center. The statement will be in sufficient detail to allow the U.S. Forest Service to verify expenditures authorized. The itemized statement for reimbursement will also include the following information:

1. Areas patrolled and miles traveled on NFS lands.
2. Person-hours worked in NFS patrol areas.
3. Copies of completed Daily Activity Reports.
4. Copies of invoice submitted.

By execution of this modification, Clackamas County certifies that the individuals listed in this document, as representatives of Clackamas County, are authorized to act in their respective areas for matters related to this instrument.

The statement should be sent to the following address:

USDA Forest Service, Law Enforcement & Investigations
Northern Oregon Zone
ATTN: Andy Coriell, Captain
16400 Champion Way
Sandy, OR 97055

B. For reimbursement of services provided under Sections V-B-1 and V-B-3 of this agreement, billing instructions will be specified in the revised Operating Plan.

C. For reimbursement of services provided under Section V-B-2 of this agreement, the following billing procedure will be used.

Incident management personnel will prepare an Emergency Use Invoice and, upon concurrence of the Cooperator, will submit the invoice for payment along with all required documentation using normal incident business procedures.

The designated representative, IMT official, or a designated forest incident business official, will approve the invoice and submit to the Albuquerque Service Center, Incident Finance, for payment along with a copy of the current Operating Plan.

D. The following is a breakdown of the total estimated costs associated with this Annual Operating Plan.

Category	Estimated Costs	Not to Exceed
Patrol Activities	$27,973.00	$27,973.00
Equipment	$0	$1,000.00 (from Patrol Activities amount)
Special Enforcement Situations	$0	$0
Total	**$27,973.00**	**$27,973.00**

E. Any remaining funding in this Annual Operating Plan may be carried forward to the next calendar year and will be available to spend through the term of the Cooperative Law Enforcement Agreement, or deobligated at the request of the U.S. Forest Service. *See Cooperative Law Enforcement Agreement Provision IV-C.*

F. By signature below, each party certifies that the individuals listed in this document as representatives of the individual parties are authorized to act in their respective areas for matters related to this agreement.

In witness whereof, the parties hereto have executed this Annual Operating Plan as of the last date written below.

Craig Roberts 8/20/19

CRAIG ROBERTS, Sheriff Date
County of Clackamas

RICHARD PERIMAN, Forest Supervisor Date
U.S. Forest Service, Mt. Hood National Forest

JIM BERNARD, County Commissioner Chair Date
County of Clackamas

John Byas 5/6/19

JOHN BYAS, Special Agent in Charge Date
U.S. Forest Service, Pacific Northwest Region

The authority and format of this modification (18-LE-11060600-007 Mod 1) have been reviewed and approved for signature.

JESSICA CLARK Digitally signed by JESSICA CLARK Date: 2019.05.03 12:39:25 -07'00'

JESSICA CLARK Date
U.S. Forest Service Grants Management Specialist

CLACKAMAS COUNTY

NANCY S. BUSH
DIRECTOR

DEPARTMENT OF DISASTER MANAGEMENT
COMMUNICATIONS AND EMERGENCY OPERATIONS CENTER
2200 KAEN ROAD OREGON CITY, OR 97045

September 5, 2019

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of an Amended Subrecipient Agreement between the City of Portland and Clackamas County for purchase and reimbursement activities related to the use of the FY17 United States Department of Homeland Security's Urban Area Security Initiative (UASI) grant program

Purpose/Outcomes	The Subrecipient Agreement between the City of Portland and Clackamas County is to allow Clackamas County and its sub-recipients to purchase and receive reimbursement for approved expenditures under the FY17 UASI grant program. This amendment removes the condition requiring compliance with City of Portland Procurement.
Dollar Amount and Fiscal Impact	$2,496,835 of FY UASI funds will directly benefit law enforcement, fire, public works and emergency management within the Portland Urban Area in the form of funding equipment and planning. $800,000 will directly benefit Clackamas County.
Funding Source	The funding source for the FY18 UASI grant is the United States Department of Homeland Security via the Oregon Military Department.
Duration	The agreement is effective from the date both parties have signed and shall end, unless otherwise terminated or extended, on May 31, 2020.
Previous Board Action/Review	The Board of County Commissioners approved the FY17 UASI Intergovernmental Agreement with the City of Portland on May 24, 2018, agenda item E.2.
Strategic Plan Alignment	1. Coordination and Integration of Planning and Preparedness 2. Ensure Safe, Healthy and Secure Communities
Counsel Review	July 1, 2019
Contact Person	Nancy Bush, Director – Emergency Management - 655-8665
Contract No.	N/A

BACKGROUND:
The Urban Area Security Initiative (UASI) is comprised of the City of Portland and the contiguous counties of Clackamas, Multnomah, Washington, Columbia and Clark County, Washington. In FY17, $2,496,835 was awarded to the UASI region. $800,000 of the total directly benefited Clackamas County.

RECOMMENDATION:
Staff respectfully recommends the Board approve this amendment.

Respectfully submitted,

Nancy Bush, Director

INTERGOVERNMENTAL AGREEMENT

Between

THE CITY OF PORTLAND, OREGON

and

Clackamas County

AMENDMENT #1

This is Amendment #1 to Contract # 30006429 between the City of Portland ("City") and Clackamas County, Oregon ("Agency").

THE AGREEMENT IS AMENDED AS FOLLOWS:

Section 2 is amended to remove the condition in subsection c) requiring compliance with City procurement rules and replace this subsection with the following language:

c) To comply with all State procurement requirements, including ORS 279A (Public Contracting – General Provisions) and ORS 279B (Public Contracting – Public Procurements).

All other terms and conditions shall remain unchanged and in full force and effect.

This amendment may be signed in two (2) or more counterparts, each of which shall be deemed an original, and which, when taken together, shall constitute one and the same amendment. The parties agree the City and Agency may conduct this transaction by electronic means, including the use of electronic signatures.

City of Portland

_____ Date_____

APPROVED AS TO FORM

_____ Date_____

Attorney

Clackamas County, Oregon

_____ Date_____

APPROVED AS TO FORM

_____ Date 08/08/2019

Attorney

COUNTY COUNSEL DOCUMENT REVIEW
TRANSMITTAL FORM

DATE: 7/1/19

TO: COUNTY COUNSEL
ATTORNEY: Andrew Naylor

FROM: Nancy Bush **(name)**

EXTENSION: x86065 **DEPARTMENT/DIVISION:** Disaster Mgmt

BILL TO Disaster Mgmt. **(Department/Division to be billed)**

TYPE OF DOCUMENT: IGA

NAME OF DOCUMENT: Clackamas UASI 2017 Amendment #1

REQUESTED RETURN DATE: August 8, 2019

APPROVED AS TO FORM:

County Counsel: [signature] **Date:** 08/08/2019

Counsel Comments:

Burden Statement

According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0596-0217. The time required to complete this information collection is estimated to average 3 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

The U.S. Department of Agriculture (USDA) prohibits discrimination in all its programs and activities on the basis of race, color, national origin, age, disability, and where applicable, sex, marital status, familial status, parental status, religion, sexual orientation, genetic information, political beliefs, reprisal, or because all or part of an individual's income is derived from any public assistance. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternative means for communication of program information (Braille, large print, audiotape, etc.) should contact USDA's TARGET Center at 202-720-2600 (voice and TDD).

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call toll free (866) 632-9992 (voice). TDD users can contact USDA through local relay or the Federal relay at (800) 877-8339 (TDD) or (866) 377-8642 (relay voice). USDA is an equal opportunity provider and employer.

CLACKAMAS COUNTY COMMUNITY CORRECTIONS
1024 MAIN STREET • OREGON CITY • OREGON • 97045
TELEPHONE 503-655-8603 • • • FAX 503-650-8942

Capt. Jenna Morrison
Director

September 5, 2019

Board of County Commissioners
Clackamas County

Members of the Board:

Approval Intergovernmental Agreement between Clackamas County Community Corrections and City of Happy Valley to Provide Work Crew Services

Purpose/Outcomes	This IGA allows Community Corrections to provide offender work service crews for the City of Happy Valley.
Dollar Amount and Fiscal Impact	The IGA will provide approximately $38,600 in revenue to support the Community Service program.
Funding Source	City of Happy Valley.
Duration	Effective once signed and terminates June 30, 2020.
Previous Board Action	Annual Renewal
Strategic Plan Alignment	1. Provide clients with a pro-social opportunity to give back to the community and be accountable for their offense. 2. Alternative sentence saving money from jail beds not used.
Contact Person	Capt. Malcolm McDonald, Director - Community Corrections 503-655-8717

BACKGROUND: Clackamas County Community Corrections will provide supervised offender work crews for sites under the control of City of Happy Valley. Crews consisting of a minimum of four offenders perform landscaping, cleanup, and graffiti removal for up to approximately six hours per day. Community Corrections provides a Corrections Officer to supervise each crew. This Agreement provides a way for offenders to give back to the communities they have victimized while generating revenue for the program. The $200 to $425 per crew fee helps to offset the cost of staff supervision, tools, and transportation to and from the site. The term of this Agreement is for one year, July 1, 2019 through June 30, 2020, and allows for three additional one-year renewals.

RECOMMENDATION: Community Corrections respectfully requests that the Board of County Commissioners approve this Intergovernmental Agreement to provide work service crews to City of Happy Valley.

Respectfully submitted,

Malcolm McDonald, Director
Community Corrections

INTERGOVERNMENTAL AGREEMENT
BETWEEN CLACKAMAS COUNTY
AND CITY OF HAPPY VALLEY

THIS AGREEMENT (this "Agreement") is entered into and between Clackamas County ("County"), a political subdivision of the State of Oregon, by and through the Community Corrections Department, and City of Happy Valley ("Agency"), 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.

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 on July 1, 2019, and shall expire as set forth herein or on June 30, 2020, but may be renewed for three (3) additional one (1) year terms upon written approval by both parties.

2. **Rights and Obligations of the County.**

   A. The County agrees to:

      i. Provide a Work Crew Supervisor to supervise the Work Crews and perform work when safety and work flow allow.
      ii. Provide a minimum of four (4) clients to perform general labor on a mutually agreed-upon schedule. Work crews will take (2) 15 minute breaks (non-billable) and (1) 30 minute lunch (non-billable) per County Policy. Total labor hours including mobilization will be a minimum of twenty- four (24) per work day.
      iii. Provide all basic tools to perform the assigned scope of work under Section 3.A.ii below. Basic tools include: (Axes, Brooms, Chainsaws, Garden Rakes, Hand Saws, Hoes, Lawn Mowers, Leaf Blowers, Litter Pickers, Loppers, Machetes, Mattocks, Pitchforks, Pruning Shears, Shovels, String Trimmers, and Wheel Barrows.) If special tools are necessary, they shall be provided by the Agency.

   B. For Graffiti removal services County agrees to:

      i. Provide a Work Crew Supervisor to supervise the Work Crew and perform work when safety and work flow allow;
      ii. Provide a minimum of two (2) clients to perform labor on mutually agreed schedule;
      iii. Provide all necessary tools to perform scope of work; including pressure washer, buckets, brushes, and Agency approved graffiti removal chemicals when necessary. (SDS available);
      iv. Perform the requested work within ten (10) days of notification from the Agency;
      v. Take before and after photos for documentation and furnish to Agency upon completion;

vi. Proactively notify Agency of any painted graffiti and address it with consent from Agency.

3. **Rights and Obligations of the AGENCY.**

A. The Agency agrees to:

i. Identify Work Crew projects, such as litter patrol, trail, and landscape maintenance in Clackamas County.
ii. Schedule Work Crew projects on a mutually agreed-upon schedule; communicating the scope of work and tool requirements to County.

B. For Graffiti removal services Agency agrees to:

i. Promptly notify County of painted graffiti once it has been determined that County will be contracted for graffiti removal;
ii. Provide County with a detailed description of the location and nature of the graffiti to be removed and ensure access for removal;
iii. When paint over is the identified best remedy, Agency will provide paint to County for an accurate color match;
iv. Agency will not Contract County in instances where ladders or man lifts are required or work has extreme grade or other inherent dangers beyond County's mutually understood capabilities.

4. **Compensation.**

A. The Agency agrees to pay $425 per crew per day for the services outlined in Section II. A.
B. For Graffiti removal services outlined in section II.B above, Agency agrees to pay $200 per event for maximum of nine (9) hours of labor. Events requiring more than nine (9) hours will be charged a rate of $400 per event.
C. Payments shall be made on the basis of requests for payment submitted as follows:

i. County will bill the Agency within the first week following the last working day of each calendar month in which work is performed;
ii. The Agency agrees to pay County within 30 days of the receipt of the County's invoice.

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 Agency may terminate this Agreement in the event the Agency fails to receive expenditure authority sufficient to allow the Agency, 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 either the Project under this Agreement is prohibited or the Agency 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, except for attorneys' fees, 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, except for attorneys' fees, 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 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. Fred Weinberg, or their designee, will act as liaison for the County.

   Contact Information:

   Fred Weinberg
   Clackamas County
   Community Corrections
   1024 Main St.
   Oregon City, OR 97045
   (503) 650-8929

   Chris Randall, or their designee, will act as liaison for the Agency.

   Contact Information:

   Chris Randall
   City of Happy Valley
   16000 SE Misty Drive
   Happy Valley, OR 97086
   (503) 783-3842

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 person 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. **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.** 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.

K. **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 and absolute discretion. County's 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.

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 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.

Q. **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.

[Signatures on Following Page]

IN WITNESS HEREOF, the Parties have executed this Agreement by the date set forth opposite their names below.

Clackamas County
Chair Jim Bernard
2051 Kaen Rd
Oregon City, OR 97045
(503) 655-8581

City of Happy Valley
City Manager, Jason Tuck
16000 SE Misty Drive
Happy Valley, OR 97086
(503) 783-3842

_____
Chair, Board of County Commissioners

_____
Date

_____
Recording Secretary

_____
City Manager, City of Happy Valley

7/29/19
Date

Recording Secretary

Approved as to form

_____
County Counsel

_____
City Attorney

CLACKAMAS COUNTY COMMUNITY CORRECTIONS
1024 MAIN STREET • OREGON CITY • OREGON • 97045
TELEPHONE 503-655-8603 • • • FAX 503-650-8942

Capt. Jenna Morrison
Director

September 5, 2019

Board of County Commissioners
Clackamas County

Members of the Board:

Approval Intergovernmental Agreement between Clackamas County Community Corrections and City of Gladstone to Provide Work Crew Services

Purpose/Outcomes	This IGA allows Community Corrections to provide offender work service crews for the City of Gladstone.
Dollar Amount and Fiscal Impact	The IGA will provide approximately $10,000 in revenue to support the Community Service program.
Funding Source	City of Gladstone
Duration	Effective once signed and terminates June 30, 2020.
Previous Board Action	Annual Renewal
Strategic Plan Alignment	1. Provide clients with a pro-social opportunity to give back to the community and be accountable for their offense. 2. Alternative sentence saving money from jail beds not used.
Contact Person	Capt. Malcolm McDonald, Director - Community Corrections 503-655-8717

BACKGROUND: Clackamas County Community Corrections will provide supervised offender work crews for sites under the control of City of Gladstone. Crews consisting of a minimum of four offenders perform landscaping, cleanup, and graffiti removal for up to approximately six hours per day. Community Corrections provides a Corrections Officer to supervise each crew. This Agreement provides a way for offenders to give back to the communities they have victimized while generating revenue for the program. The $200 to $425 per crew fee helps to offset the cost of staff supervision, tools, and transportation to and from the site. The term of this Agreement is for one year, July 1, 2019 through June 30, 2020, and allows for three additional one-year renewals.

RECOMMENDATION: Community Corrections respectfully requests that the Board of County Commissioners approve this Intergovernmental Agreement to provide work service crews to City of Gladstone.

Respectfully submitted,

Malcolm McDonald, Director
Community Corrections

INTERGOVERNMENTAL AGREEMENT
BETWEEN CLACKAMAS COUNTY
AND CITY OF GLADSTONE

THIS AGREEMENT (this "Agreement") is entered into and between Clackamas County ("County"), a political subdivision of the State of Oregon, by and through the Community Corrections Department, and City of Gladstone ("Agency"), 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.

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 June 30, 2020, but may be renewed for three (3) additional one (1) year agreements upon written approval by both parties.

2. **Rights and Obligations of the County.**

   A. The COUNTY agrees to:

      i. Provide a Work Crew Supervisor to supervise the Work Crews and perform work when safety and work flow allow.
      ii. Provide a minimum of four (4) clients to perform general labor on a mutually agreed-upon schedule. Work crews will take (2) 15 minute breaks (non-billable) and (1) 30 minute lunch (non-billable) per County Policy. Total labor hours including mobilization will be a minimum of twenty- four (24) per work day.
      iii. Provide all basic tools to perform assigned scope of work. Basic tools include: (Axes, Brooms, Chainsaws, Garden Rakes, Hand Saws, Hoes, Lawn Mowers, Leaf Blowers, Litter Pickers, Loppers, Machetes, Mattocks, Pitchforks, Pruning Shears, Shovels, String Trimmers, and Wheel Barrows.) If special tools are necessary, they shall be provided by the Agency.

   B. For Graffiti removal services COUNTY agrees to:

      i. Provide a Work Crew Supervisor to supervise the Work Crew and perform work when safety and work flow allow;
      ii. Provide a minimum of two (2) clients to perform labor on mutually agreed schedule;
      iii. Provide all necessary tools to perform scope of work; including pressure washer, buckets, brushes, and AGENCY approved graffiti removal chemicals when necessary. (SDS available);
      iv. Remedy requested work within ten (10) days of notification per code;
      v. Take before and after photos for documentation and furnish to AGENCY upon completion;

vi. Proactively notify AGENCY of any painted graffiti and address with consent from AGENCY.

3. **Rights and Obligations of the AGENCY.**

A. The AGENCY agrees to:

i. Identify Work Crew projects, such as litter patrol, trail, and landscape maintenance in Clackamas County.
ii. Schedule Work Crew projects on a mutually agreed-upon schedule; communicating scope of work and tool requirements to COUNTY.

B. For Graffiti removal services AGENCY agrees to:

i. Promptly notify COUNTY of painted graffiti once it has been determined that COUNTY is going to be contracted for graffiti removal;
ii. Provide COUNTY with a detailed description of the location and nature of the graffiti to be removed and ensure access for removal;
iii. When paint over is the identified best remedy, AGENCY will provide paint to COUNTY for an accurate color match;
iv. AGENCY will not Contract COUNTY in instances where ladders or man lifts are required or work has extreme grade or other inherent dangers beyond COUNTY's mutually understood capabilities.

4. **Compensation.**

A. The Agency agrees to pay $425 per crew per day for the services outlined in Section II. A.
B. For Graffiti removal services outlined in section II.B above. Agency agrees to pay $200 per event for maximum of nine (9) hours of labor. Events requiring more than nine (9) hours will be charged a rate of $400 per event.
C. Payments shall be made on the basis of requests for payment submitted as follows:
i. COUNTY will bill the Agency within the first week following the last working day of each calendar month in which work is performed;
ii. The Agency agrees to pay COUNTY within 30 days of the receipt of the COUNTY'S invoice.

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 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 Agency may terminate this Agreement in the event the Agency fails to receive expenditure authority sufficient to allow the Agency, 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 either the Project under this Agreement is prohibited or the Agency 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, except for attorneys' fees, 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, except for attorneys' fees, 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 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. Fred Weinberg, or their designee, will act as liaison for the County.

   Contact Information:

   Fred Weinberg
   Clackamas County
   Community Corrections
   1024 Main St.
   Oregon City, OR 97045
   (503) 650-8929

   Sean Boyle, or their designee, will act as liaison for the Agency.

   Contact Information:

   Sean Boyle
   City of Gladstone
   525 Portland, Avenue
   Gladstone, OR 97027
   (503) 557-2763

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 person 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. **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.** 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.

K. **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 and absolute discretion. County's 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.

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 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.

Q. **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.

[Signatures on Following Page]

IN WITNESS HEREOF, the Parties have executed this Agreement by the date set forth opposite their names below.

Clackamas County
Chair Jim Bernard
Commissioner Sonia Fischer
Commissioner Ken Humberston
Commissioner Paul Savas
Commissioner Martha Schrader

Chair, Board of County Commissioners

Date

Recording Secretary

City of Gladstone
Chief John Schmerber
525 Portland Avenue
Gladstone, OR 97027
(503 557-2764

Authorized Signature

JOHN SCHMERBER
Printed Name/Title

8/6/19
Date

Approved as to form

County Counsel

CLACKAMAS COUNTY

Evelyn Minor-Lawrence
Director

DEPARTMENT OF HUMAN RESOURCES

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

September 5, 2019

Board of County Commissioners
Clackamas County

Members of the Board:

Retroactive Approval of 2018 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 2018 and five Summary Plan Descriptions for the 2018 plan year.
Dollar Amount and Fiscal Impact	The fiscal impact for the 2018 plan year was: $22,443,235.80 The estimated fiscal impact for the 2019 plan year is: $23,403,713.28
Funding Source	Department, employee, and retiree contributions
Duration	Effective January 1, 2018 – December 31, 2018
Previous Board Action	This agreement is pending Board of County Commissioners (BCC) review at the county issues meeting on September 4, 2019.
County Counsel Review	This Administrative Services Agreement and the five summary plan descriptions have been reviewed and approved by County Counsel on May 8, 2019.
Strategic Plan Alignment	Builds public trust through good government.
Contact Person	Kristi Durham, Human Resources, 503.742.5470

BACKGROUND:
At the county issues meeting on September 4, 2019, the Board of County Commissioners will review the 2018 and 2019 Providence medical plan renewals. The Providence plan Administrative Services Agreement and the Summary Plan Descriptions require the board's approval and signature.

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

The 2019 Administrative Services Agreement and Summary Plan Descriptions will be available for signature after Providence receives the signed 2018 documents.

RECOMMENDATION:
Staff recommends the Board retroactively approve the 2018 Administrative Services Agreement and Summary Plan Descriptions from Providence Health Plan.

Sincerely,

Kristi Durham, Benefits Manager
Department of Human Resources

THIS ADDENDUM NO. 3 TO THE ADMINISTRATIVE SERVICES AGREEMENT (**"Addendum"**) is entered into as of January 1, 2018, by and between Clackamas County (**"Plan Sponsor"**), and Providence Health Plan (**"Providence"**). Plan Sponsor and Providence are sometimes referred to in this Addendum 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.

ADDENDUM

THE PARTIES AGREE AS FOLLOWS:

1. **Revised Exhibit B.** Exhibit B to the Services Agreement is amended and replaced in its entirety with the revised Exhibit B, attached hereto as Schedule 1.

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

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 Addendum. After the date of this Addendum, any reference to the Services Agreement shall mean the Services Agreement as amended by this Addendum.

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

By:	**Providence Health Plan**
Signature:	Brad Garrigues
Name:	Brad Garrigues
Title:	Chief Sales & Marketing Officer
Date:	8/23/2019

By:	**Clackamas County**
Signature:	_____
Name:	_____
Title:	_____
Date:	_____

SCHEDULE 1

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, 2018 through December 31, 2018.

Core Package of Services	
	Note: PEPM means Per Employee Per Month
Medical Claims Administration	$26.83 PEPM
Pharmacy Claims Administration / Management	$5.14 PEPM *(0% of rebates retained by Providence)*
Providence ASO Network	$8.18 PEPM
Medical, Case and Disease Management	$8.90 PEPM
MHCD with Administration, Utilization Management and Network Services by PBH	$4.82 PEPM
Alternative Care/Chiropractic Care Administration & Network (ASH Network; PHP processing)	$2.19 PEPM
Health Coaching – 12 Sessions	$2.01 PEPM
Total Monthly Administrative Fee	**$58.07 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
Life Balance	No additional charge
TruVision & TruHearing (available only in OR and SWWA)	No additional charge
Affinity (available only in OR and SWWA)	No additional charge

CLACKAMAS COUNTY GENERAL COUNTY EMPLOYEES PERSONAL OPTION PLAN

SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

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 Employee Services: 503-655-8459

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) www.ProvidenceHealthPlan.com
Mail order prescription drug services	www.ProvidenceHealthPlan.com
Medical Prior Authorization requests	800-638-0449 (toll-free)
Mental Health / Substance Abuse Prior Authorization	800-711-4577 (toll-free)
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

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 Network Providers; and
    - Providence Health Plan's national network of Network Providers.
- Covered Services must be obtained from 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 Network Providers in our Service Area is available at http://phppd.providence.org/. 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 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 a Network Provider.

If you are unsure about a physician/provider's, Hospital's or other facility's participation with Providence Health Plan, visit the Provider Directory, available online at http://phppd.providence.org/, before you make an appointment. You also can call Customer Service to get information about a provider's participation with Providence Health Plan and your benefits.

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 Network Providers, available online at http://phppd.providence.org/. 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** through our automated voice-recognition phone as well as 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 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.

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.

2.8 PRIVACY OF MEMBER INFORMATION

At Providence Health Plan, we respect the privacy and confidentiality of your protected health information (PHI). Providence Health Plan takes great care to determine when it is appropriate to share your PHI, in accordance with federal and state privacy laws. Providence Health Plan may use protected health information and may share it with others as part of your treatment, payment for your treatment, and our business operations.

The following are ways Providence Health Plan may use or share information about you, consistent with law:

- We will use the information to administer your benefits and help pay your medical bills that have been submitted to us for payment.
- We may share your information with your doctors or Hospitals to help them provide medical care to you (e.g., if you are in the Hospital, we may give them access to any medical records sent to us by your doctor).
- We may use or share your information with others to help manage your health care (e.g., we might talk to your doctor to suggest a disease management or wellness program that could help improve your health).
- We may share your information with individuals who perform business functions for us. We will only share your information if there is a business need to do so and if our business partner agrees to protect the information.
- We may use your information to provide you with information about alternative medical treatments and programs or about health related products and services that you may be interested in (e.g., we sometimes send out newsletters that let you know about “healthy living” alternatives such as smoking cessation or weight loss programs).

Providence Health Plan makes every effort to release only the minimum amount of information necessary to meet any release requirement and only release information on a need to know basis. Also, wherever feasible, identifiable information is removed from any information shared.

To secure the confidentiality of medical information, Providence Health Plans has procedures in place which you can review at www.ProvidenceHealthPlan.com/privacy.

When Member information is used in health studies, identifiable information is not released. All Member-specific information has identifying information removed, and aggregated data are used as early in the measurement process as possible. The privacy of our Members is completely protected.

Our agreements with Network Providers contain confidentiality provisions that require providers treat your personal health information with the same care.

You have the right to ask us to restrict how we use or disclose your information for treatment, payment or health care operations. You also have the right to ask us to restrict information we may give to persons involved in your care. While we may honor your request for restrictions, we are not required to agree to these restrictions. You have the right to ask us to redirect and send your own personal protected health information to you only and directly as permitted by current privacy laws. You also have the right to register a complaint if you believe your privacy is compromised in any manner.

Members may request to see their medical records. Call your physician’s or provider’s office to ask how to schedule a visit for this purpose.

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

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. Although allowable by HIPAA, Providence Health Plan's practice is to deidentify, or masks personal identifiers, on claims data released for these purposes.

In all other circumstances, Providence Health Plan does not disclose a Member's PHI to an employer or any agent of the Employer, Should Providence Health Plan change this practice, a Member's PHI would not be released to an Employer or any agent of the Employer unless Providence Health Plan determines that such disclosure is:

1. In compliance with the applicable provisions of HIPAA; and
2. 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, under which the Employer agrees to limit further disclosures to those permitted by law and plan documents, to ensure that any person or subcontractor with whom the PHI is disclosed makes similar agreements, not to use PHI for employment-related actions or decisions, not to use PHI for purposes related to any other benefits, to provide access to individuals to their PHI except as limited by law, to amend PHI as provided by law, to account for access to and disclosures of PHI as provided by law, to provide Providence Health Plan information Providence Health Plan may need to provide individuals with accountings of disclosures, to be audited by the US Department of Health & Human Services as to its handling of PHI, to return all PHI to Providence Health Plan when no longer required, to identify employees or classes of employees that need access to PHI and to prevent access to PHI for employees or classes of employees who are not identified as needing access to PHI, and to report to Providence Health Plan any violations of these principles. An Employer who receives PHI from Providence Health Plan must maintain policies and procedures that demonstrate compliance with the foregoing expectations, including procedures for the return, destruction and restriction of further use of PHI, and procedures for taking action if employees or subcontractor's inappropriately use or disclose PHI.

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. Providence Health Plan will only use or disclose a Member's PHI for treatment purposes, operational purposes, payment purposes, or for any reasonable purposes to which the Member has consented.

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 NETWORK PROVIDERS

Providence Health Plan has contractual arrangements with certain physicians/providers, hospitals and facilities located in Oregon and southwest Washington, as well as Nationwide. Our agreements with these "Network Providers" enable you to receive quality health care for a reasonable cost.

For Services to be covered, you must receive Services from Network Providers. It is your responsibility to verify whether or not a physician/provider, hospital or other facility is participating with us even if you have been directed or referred for care by a Network Provider.

3.1.1 Nationwide Network of 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 Network Providers, even when you are outside of Oregon and southwest Washington.

3.1.2 Choosing a Network Provider

To choose a Network Provider, or to verify if a provider is a Network Provider, please refer to the Provider Directory, available online at http://phppd.providence.org/. If you do not have access to our website, please call Customer Service to request Network Provider Information.

> Your 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 a 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 a 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: 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 Network Providers with the specialties listed above are Network Primary Care Providers. Please refer to the Provider Directory, available online, for a listing of designated Network Primary Care Providers or call your Customer Service team to request a hard copy.

3.2.2 Established Patients with Primary Care Providers

If you and your family already see a provider, you may want to check the provider directory to see if your provider is a Network Primary Care Provider for Providence Health Plan. If your provider is participating with us, let his or her 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 he or she is accepting new patients. It is a good idea to have your previous physician or provider transfer your medical records to your new Primary Care Provider as soon as possible. The first time you make an appointment with your Primary Care Provider, let him or her know you are now a Providence Health Plan Member. On your first visit, make a list of questions or information you would like to discuss with your new Primary Care Provider, including the following:

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

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

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 who specializes in treatment for your condition.

Other Providers (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 condition.

You also may decide to see a specialist without consulting your Primary Care Provider. Visit the Provider Directory, available online at http://phppd.providence.org/, or call Customer Service to choose a specialist who is a 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 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 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	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 Network Pharmacies (see section 4.14.1**.** A list of our Network Pharmacies is available online at www.ProvidenceHealthPlan.com. You also may contact Customer Service if you need help locating a Network 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 a 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 Prior Authorization does not supersede other specific provisions of this Plan regarding coverage, limitations, exclusions and Medical Necessity.

Services received from Network Providers:
When Services are received from a Network Provider, the 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 Non-Participating 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.
- All Travel Expense Reimbursement, as provided in section 3.8.
- All inpatient, residential and 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.
- 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 a 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 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 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. If your Approved Clinical Trial is available through both Network and Out-of-Network providers, the Plan will require you to participate through a 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.

3.12 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 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 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/womensguidelines.

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

4.1.1 Physical Examinations and Well-Baby Care

Periodic health exams and well-baby care Services are covered in full only when received In-Network. These services are covered as stated in your Benefit Summary. Your provider will determine which tests are necessary for your physical exam according to your medical history and your current health status. More frequent exams will be covered if your provider determines that they are necessary. Vision and hearing screening services are covered when performed during a periodic health examination or well-baby care examination. 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 4.9.5.

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 Network 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 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.

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 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 (HbAlc) 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

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.

4.2.4 Family Planning Services

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

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

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

  Services are covered in full and must be received from Network Providers and Facilities. Oral contraceptives must be purchased at Network Pharmacies.

4.2.5 Women's Elective Sterilization

Coverage is provided, as stated below, for women's voluntary sterilization (tubal ligation).

All Covered Services must be received from Qualified Providers and Facilities. Services are covered in full and must be received from 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 Network facilities.

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 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 Network Providers. Not all Network Providers are contracted with us to provide Phone and Video Visits. 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 a 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 Network Providers.

4.3.3 E-visits

E-visits are covered in full and must be received from Network Providers. Not all Network Providers offer E-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-visits. Network Providers who are authorized to provide E-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-visit benefit, you must have had at least one prior office visit with your Network Provider within the last 12 months.

Covered E-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 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 email communications that do not qualify as E-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 and Injectable 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. 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 Urgent Care, call your Primary Care Provider first. Your Primary Care Provider or the provider-on-call is always available, day or night. He or she may either suggest that you 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
- Unexpected premature childbirth
- Acute abdominal pain
- Severe chest pain
- Serious burn
- Bleeding that does not stop
- Medically Necessary detoxification

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

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 care or to a facility specified by Providence Health Plan.

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 or our authorizing agent 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 a 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 or their authorizing agent.

4.5.5 Urgent Care

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

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

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 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 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

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. 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 shown 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. (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 specified in section 4. 11.

4.7.3 Outpatient Habilitative Services

Coverage is provided for Medically Necessary outpatient habilitative Services for maintenance, learning or improving skills and function for daily living. 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 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, 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* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within time frames outlined in Newborn Eligibility and Enrollment, section 8.2.4.

*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. See section 8.2.4 regarding newborn eligibility and enrollment.

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

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

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-Network.

4.9 MEDICAL SUPPLIES, MEDICAL APPLIANCES, PROSTHETIC AND ORTHOTIC DEVICES, DURABLE MEDICAL EQUIPMENT (DME) AND STATE MANDATED HEARING AID BENEFIT

Benefits for medical supplies, medical appliances, prosthetic and orthotic devices, Durable Medical Equipment (DME) and hearing aids 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, lancets and test strips, may be purchased through Providence Health Plan medical supply providers or under this benefit at Network Pharmacies. Unless there is a medical exception on file, diabetes test strips are limited to products listed on the pharmacy formulary and are restricted to100 test strips per month for insulin dependent Members and 100 test strips every three months for non-insulin dependent Members. See section 4.9.4 for coverage of diabetic equipment such as glucometers and 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 additional to any Copayment or Coinsurance for the procedure.
6. Other Medically Necessary appliances 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 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).

4.9.5 Hearing Aids and Hearing Exams

Medically Necessary external hearing aids and devices, one per ear per every four calendar years, as prescribed, fitted, and dispensed by a licensed audiologist or a hearing aid/instrument specialist, are covered under this Plan. “Hearing aids and devices” are defined as any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries and cords.

Office visits for routine hearing exams and tests, including those related to the evaluation/fitting of a hearing aid, will be payable under this Plan at the office visit benefit level as shown in your Benefit Summary.

4.9.6 Wigs

The Plan will provide coverage for one synthetic wig every calendar year for Members who have undergone chemotherapy or radiation therapy 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.

4.10 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

This Plan complies with Oregon and Federal Mental Health Parity.

4.10.1Mental 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, and day, intensive outpatient, or partial hospitalization Services. All inpatient, residential, and 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 or our authorizing agent;
- 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, neurofeedback, 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 or our authorizing agent, 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, and day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan or their authorizing agent.

Prior Authorization is required for all inpatient, residential, and 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.
5.

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.

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 or 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 trauma, infection or other diseases and for congenital deformities and anomalies if there is a resultant functional impairment. 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 pain, or restoring facial configuration or functions such as speech, swallowing or chewing. 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 malocclusion of the 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 shorten or lengthen the upper or lower jaw, unless related to a traumatic injury or to a neoplastic or degenerative disease; and
- Services to treat temporomandibular joint syndrome, 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 a 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 when received from a Network 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 Men's Elective Sterilization Services

Covered Services include men's voluntary sterilization (vasectomy). All Covered Services must be received from Qualified Providers and Facilities. Services are covered subject to the provisions of the applicable benefit, e.g., your Outpatient Surgery benefit. Services to reverse a prior sterilization procedure are not covered.

***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.

4.12.13 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. 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.

4.13 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 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 Deductible, Coinsurance, and Copayment provisions of this Plan are waived, except as follows:

The Member/recipient is responsible for the Deductible, Coinsurance or Copayment amounts, as shown in the Benefit Summary, for inpatient Hospital Services and for outpatient facility Services that are not billed as a global fee and those amounts 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 Network 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 Network Pharmacy.

You have broad access to over 26,000 Network Pharmacies and their services at discounted rates.

Providence Health Plan Network 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.

Network Pharmacies are designated as retail, preferred retail, specialty and mail-order Pharmacies. To view a list of Network 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 Network 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 the 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.
- Network 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 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 Network 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 purchase 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 Network mail-order Pharmacies. To find our Network 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 a Network 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 glucometers and 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 us 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 Network 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.

4.14.3 Prescription Drug Formulary

The Providence Health Plan Formulary is a list of Food and Drug Administration (FDA)-approved prescription generic, brand and specialty 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 added to the formulary. 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.

4.14.4 Prescription Drugs

Generic and Brand-Name 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 your brand-name benefit includes a Copayment or Coinsurance, regardless of the reason or Medical Necessity, and you request a brand-name drug, 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 in 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 Network Pharmacies as required by the ACA. Over-the-counter ACA preventive drugs received from Network Pharmacies will not be covered in full under the ACA preventive benefit without a written prescription from your Qualified Practitioner.

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; and
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; and
5. FDA-approved women's prescription contraceptives: up to 3-months initial dispensing, then up to 12-months subsequent dispensing at any of our Network Pharmacies.

Other dispensing limits may apply to certain medications requiring limited use, as determined by our medical policy. Prior Authorization is required for amounts exceeding any applicable medication dispensing limits.

4.14.6 Network 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 Network 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 there is a negative change in our Network mail-service or preferred retail Pharmacies, you will be notified of the change at least 30 days in advance.

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 therapeutic amount and must be purchased at a Network 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 Network 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.

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 for 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 hyperactivity in children and adults;
3. Drugs or medications prescribed that do not relate to the treatment of a covered illness or injury;
4. Drugs used for the treatment of fertility/infertility;
5. Fluoride, for Members over the age of 16 years old;
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, medications 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;
11. 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); and
20. Vaccines, immunizations and preventive medications solely for the purpose of travel, school, or work.

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 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 self-administered (except as provided in 4.12.8), are prescribed by you for your own benefit, or are provided or prescribed by a person who resides in your home or is a member of your family. "Member of your family" for this purpose means any person who could possibly inherit from you under the intestate succession law of any state, plus any in-law, step relative, foster parent, or domestic partner of you or of any such person;
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos and books, educational programs to which drivers are referred by the judicial system, and volunteer mutual support groups;
- Are provided to yield primarily educational outcomes. 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;
- 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 disputed 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, 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;
- 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); and
- Relate to participation in a civil revolution or riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.

The Plan does not cover:

- Charges that are in excess of Usual, Customary, and Reasonable (UCR) costs;
- Custodial Care;
- Transplants, except as provided in section 4.13;
- Services for Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, Durable Medical Equipment (DME) and Hearing Aids, 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;
- 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 and 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 unless approved by us in advance.
- Conditions for mental and nervous conditions that are specified as excluded in section 15. Definitions, for Mental Health and Substance Abuse;
- 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, 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; and
- Dance, poetry, music or art therapy, except as part of an approved treatment program.

Exclusions that apply to <u>Provider Services</u>:

- 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 services for the treatment of infertility, including all services related to surrogate parenting. For the purpose of this exclusion, infertility is defined as the inability to become pregnant after a year of unprotected intercourse or the inability to carry a pregnancy to term as evidenced by three consecutive spontaneous abortions;
- 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;
- Condoms and other over-the-counter birth control products; 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 parts or batteries;
- Replacement of lost or broken hearing aids;
- Repair of hearing aids are not covered. Repair needs should be discussed with your provider via your warranty period;
- Hearing aids prescribed and ordered prior to coverage, or prescribed or ordered after termination of coverage, whichever occurs first;
- Bone anchored hearing aids; and
- Hearing aids, hearing therapies and/or devices, except as provided in section 4.9.5.

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 provided 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 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 notify the provider and the provider will have 45 days to submit the additional information. Within two days of receipt of the additional information, Providence Health Plan will complete their review and notify your provider or you of their decision. If the information is not received within 45 days, the request will be denied.
- **For 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 services that involve 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 may 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 743.847, 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

Mental Health and Substance Abuse claims should be submitted to:

PBH
PO Box 30602
Salt Lake City, UT 84130

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.

B.

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.

C. 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.

D. 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.

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

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

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.

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 Network Providers or payment for Services by Out-of-Network Providers, please ask for Providence Health Plan's help. Customer Service 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;
- Imposition of a pre-existing condition exclusion, source-of injury exclusion, network exclusion, Annual benefit limit or other limitation on otherwise Covered Services;
- Determination that a health care item or service is 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 consent 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, upon request and free of charge, have reasonable access to and copies of the documents and records, and other information relevant to our decision, including the specific internal rule, guideline, protocol, or other criterion relied upon to make an Adverse Benefit Determination.
- You can be represented by anyone of your choice at all levels of 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 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 that 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 Voluntary Second Level Internal Appeal

If you are not satisfied with the decision of the internal Appeal 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, or (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care, you may request a voluntary second level internal Appeal. If your case is eligible, it will be reviewed by Providence Health Plan's Grievance Committee. The members of the Grievance Committee are made up of individuals not involved in the initial decision to uphold an Appeal. You must submit your written request for the voluntary second level internal Appeal within 60 days of the date on the internal Grievance or Appeal decision notice or that initial decision will become final. The Grievance Committee will review all documentation presented by you and send a written explanation of its decision within 30 days of receiving your request for the voluntary second level internal Appeal.

7.2.4 External Review

If you are not satisfied with the internal Grievance or Appeal decision or the decision of the voluntary second level internal Appeal 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, or (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care, 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 voluntary second level internal 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, or (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care.**

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.**

7.2.5 How to Submit Grievances or Appeals and Request Appeal Documents

To submit your Grievance or Appeal, 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 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 on this Plan. You and your Employer must provide us 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 Employee Services. .

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 Employee Services.

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 his or her Spouse or Domestic Partner may elect continuation coverage for all covered Family Members. In addition, each Family Member has an independent right to elect COBRA. Thus, a Family Member may elect continuation coverage even if the 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 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 his or her covered Family Members may continue for up to 29 months from the date of the original qualifying event, or loss of coverage, whichever is later. The 29-month period applies only if the following conditions are met:

- The Social Security Administration (SSA) determines that the qualified beneficiary is disabled at any time prior to the qualifying event or during the first 60 days of COBRA continuation coverage; and
- The qualified beneficiary provides 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 that has no exclusions or limitations with respect to any pre-existing conditions. If the other plan has applicable exclusions or limitations, the COBRA continuation coverage will terminate after the exclusion or limitation no longer applies'
- The qualified beneficiary (employee, spouse, or dependent child) later becomes entitled to Medicare;
- The earliest date that the qualified beneficiary no longer qualifies for such coverage in accordance with the federal COBRA regulations; or
- The applicable maximum period of continuation coverage occurs.

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 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 NONWAIVER

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
Risk & Benefit 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 his/her 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 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**.**

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 a 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 to pay 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.

Director

Director means the director of the Oregon Department of Consumer and Business Services.

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.

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. Coverage is effective on the earlier of the first day of the next month following the completion of the Eligibility Waiting Period. 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.
5. Effective Date of Coverage: 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

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 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.

3) 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.

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.

E-visit

E-visit (electronic provider communications) means a consultation through email with a Network Provider that is, in the judgment of the Network Provider, Medically Necessary and appropriate and involves a significant amount of the Network Provider's time. An E-visit must relate to the treatment of a covered illness or injury (see also section4.3.3).

Exclusion

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

Experimental/Investigational

Experimental/Investigational means those Services that are determined by Providence Health Plan not to be Medically Necessary or accepted medical practice in the Service Area, including Services performed for research purposes. In determining whether Services are Experimental/Investigational, Providence Health Plan will consider whether the Services are in general use in the medical community in the U.S.; whether the Services are under continued scientific testing and research; whether the Services show a demonstrable benefit for a particular illness or disease; whether they are proven to be safe and efficacious; and whether they are approved for use by appropriate governmental agencies. Providence Health Plan determines on a case-by-case basis whether the requested Services will result in greater benefits than other generally available Services, and will not approve such a request if the Service poses a significant risk to the health and safety of the Member. Providence Health Plan will retain documentation of the criteria used to define a Service deemed to be 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.

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).

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

1. The Service is medically indicated according to the following factors:
    a. The Service is necessary to diagnose or to meet the reasonable health needs of the Member;
    b. The expected health benefits from the Service are clinically significant and exceed the expected health risks by a significant margin;
    c. The Service is of demonstrable value and that value is superior to other Services and to the provision of no Services; and
    d. Expected health benefits can include:
        - Increased life expectancy;
        - Improved functional capacity;
        - Prevention of complications; or
        - Relief of pain.
2. The Qualified Practitioner recommends the Service.
3. The Service is rendered in the most cost-efficient manner and type of setting consistent with nationally recognized standards of care, with consideration for potential benefits and harms to the patient.
4. The Service is consistent in type, frequency and duration with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by Providence Health Plan.

In the case of a life-threatening illness, a Service that would not meet the criteria above may be considered Medically Necessary for purposes of reimbursement, if:

- It is considered to be safe and effective as demonstrated by accepted clinical evidence reported by generally-recognized medical professionals or publications; and
- The treatment is provided in a clinically controlled research setting using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health for a life-threatening condition.

For the purpose of this exception, the term "life-threatening" means more likely than not to cause death within one year of the date of the request for diagnosis or treatment.

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.

Network Pharmacy

Network 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 Network Pharmacies:

1. Retail: a Network Pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions.
2. Preferred Retail: a Network 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 Network 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 Network Pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.

Network Provider

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 a Network Provider.

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.

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 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 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 a Network Provider, UCR means charges based on the fee that Providence Health Plan has negotiated with 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 prevalent or which would not be considered excessive in a particular case because of unusual circumstances; or
4. 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 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 a 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 a 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 می‌شود، تسهیلات زبانی به صورت رایگان برای شما فراهم می‌باشد. با (TTY: 711) 1-800-878-4445 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, 2018.

By: _____

Printed Name: _____

Title: _____

Company: _____

Date: _____

MISSION

As people of Providence,
we reveal God's love for all,
especially the poor and vulnerable,
through our compassionate service.

OUR CORE VALUES

Respect, Compassion, Justice,
Excellence, Stewardship

Administered by:

Customer Service: 503-574-7500 or 800-878-4445

Sales: 503-574-6300 or 877-245-4077

www.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.

CLACKAMAS COUNTY GENERAL COUNTY EMPLOYEES OPEN OPTION PLAN

SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

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 Employee Services: 503-655-8459

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) www.ProvidenceHealthPlan.com
Mail order prescription drug services	www.ProvidenceHealthPlan.com
Medical Prior Authorization requests	800-638-0449 (toll-free)
Mental Health / Substance Abuse Prior Authorization	800-711-4577 (toll-free)
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

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 Network Providers;
    - Providence Health Plan's national network of Network Providers; and
    - Out-of-Network Providers.
- With this Plan, Members will generally have lower out-of-pocket expenses when obtaining Covered Services from Network Providers. Members may, however, obtain most Covered Services from Non-Participating 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:
    - Virtual Visits, as specified in section 4.3.2;
    - E-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-Network.
- Coverage is provided in full for most preventive Services when those Services are received from specified 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 Network Providers is available at http://phppd.providence.org/. 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 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 Network Providers. Also, 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 a Network Provider.

If you are unsure about a physician/provider's, Hospital's or other facility's participation with Providence Health Plan, visit the Provider Directory, available online at http://phppd.providence.org/, before you make an appointment. You also can call Customer Service to get information about a provider's participation with Providence Health Plan and your benefits.

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 Network Providers, available online at http://phppd.providence.org/. 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** through our automated voice-recognition phone as well as 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 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.

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.

2.8 PRIVACY OF MEMBER INFORMATION

At Providence Health Plan, we respect the privacy and confidentiality of your protected health information (PHI). Providence Health Plan takes great care to determine when it is appropriate to share your PHI, in accordance with federal and state privacy laws. Providence Health Plan may use protected health information and may share it with others as part of your treatment, payment for your treatment, and our business operations.

The following are ways Providence Health Plan may use or share information about you, consistent with law:

- We will use the information to administer your benefits and help pay your medical bills that have been submitted to us for payment.
- We may share your information with your doctors or Hospitals to help them provide medical care to you (e.g., if you are in the Hospital, we may give them access to any medical records sent to us by your doctor).
- We may use or share your information with others to help manage your health care (e.g., we might talk to your doctor to suggest a disease management or wellness program that could help improve your health).
- We may share your information with individuals who perform business functions for us. We will only share your information if there is a business need to do so and if our business partner agrees to protect the information.
- We may use your information to provide you with information about alternative medical treatments and programs or about health related products and services that you may be interested in (e.g., we sometimes send out newsletters that let you know about “healthy living” alternatives such as smoking cessation or weight loss programs).

Providence Health Plan makes every effort to release only the minimum amount of information necessary to meet any release requirement and only release information on a need to know basis. Also, wherever feasible, identifiable information is removed from any information shared.

To secure the confidentiality of medical information, Providence Health Plan has procedures in place which you can review at www.ProvidenceHealthPlan.com/privacy.

When Member information is used in health studies, identifiable information is not released. All Member-specific information has identifying information removed, and aggregated data are used as early in the measurement process as possible. The privacy of our Members is completely protected.

Our agreements with Network Providers contain confidentiality provisions that require providers treat your personal health information with the same care.

You have the right to ask us to restrict how we use or disclose your information for treatment, payment or health care operations. You also have the right to ask us to restrict information we may give to persons involved in your care. While we may honor your request for restrictions, we are not required to agree to these restrictions. You have the right to ask us to redirect and send your own personal protected health information to you only and directly as permitted by current privacy laws. You also have the right to register a complaint if you believe your privacy is compromised in any manner.

Members may request to see their medical records. Call your physician's or provider's office to ask how to schedule a visit for this purpose.

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

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. Although allowable by HIPAA, Providence Health Plan's practice is to de-identify, or masks personal identifiers, on claims data released for these purposes.

In all other circumstances, Providence Health Plan does not disclose a Member's PHI to an Employer or any agent of the Employer, Should Providence Health Plan change this practice, a Member's PHI would not be released to an Employer or any agent of the Employer unless Providence Health Plan determines that such disclosure is:

1. In compliance with the applicable provisions of HIPAA; and
2. 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, under which the Employer agrees to limit further disclosures to those permitted by law and plan documents, to ensure that any person or subcontractor with whom the PHI is disclosed makes similar agreements, not to use PHI for employment-related actions or decisions, not to use PHI for purposes related to any other benefits, to provide access to individuals to their PHI except as limited by law, to amend PHI as provided by law, to account for access to and disclosures of PHI as provided by law, to provide Providence Health Plan information Providence Health Plan may need to provide individuals with accountings of disclosures, to be audited by the U.S. Department of Health & Human Services as to its handling of PHI, to return all PHI to Providence Health Plan when no longer required, to identify employees or classes of employees that need access to PHI and to prevent access to PHI for employees or classes of employees who are not identified as needing access to PHI, and to report to Providence Health Plan any violations of these principles. An Employer who receives PHI from Providence Health Plan must maintain policies and procedures that demonstrate compliance with the foregoing expectations, including

procedures for the return, destruction and restriction of further use of PHI, and procedures for taking action if employees or subcontractor's inappropriately use or disclose PHI.

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. Providence Health Plan will only use or disclose a Member's PHI for treatment purposes, operational purposes, payment purposes, or for any reasonable purposes to which the Member has consented.

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 PARTICIPATING PROVIDERS

Providence Health Plan has contractual arrangements with certain physicians/providers, hospitals and facilities located in Oregon and southwest Washington, as well as Nationwide. Our agreements with these "Participating 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 Network Providers. It is your responsibility to verify whether or not a physician/provider, hospital or other facility is participating with us even if you have been directed or referred for care by a Network Provider.

3.1.1 Nationwide Network of 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 Network Providers, even when you are outside of Oregon and southwest Washington.

3.1.2 Choosing a Network Provider

To choose a Network Provider, or to verify if a provider is a Network Provider, please refer to the Provider Directory, available online at www.ProvidenceHealthPlan.com. If you do not have access to our website, please call Customer Service to request Network Provider Information.

Advantages of Using a Network Provider

- Your 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 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 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 a Network Provider, including a 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 a 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 a 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: 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 Network Providers with the specialties listed above are Network Primary Care Providers. Please refer to the Provider Directory, available online, for a listing of designated Network Primary Care Providers or call your Customer Service team to request a hard copy.

3.2.2 Established Patients with Primary Care Providers

If you and your family already see a provider, you may want to check the provider directory to see if your provider is a Network Primary Care Provider for Providence Health Plan. If your provider is participating with us, let his or her 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 he or she is accepting new patients. It is a good idea to have your previous physician or provider transfer your medical records to your new Primary Care Provider as soon as possible. The first time you make an appointment with your Primary Care Provider, let him or her know you are now a Providence Health Plan Member. On your first visit, make a list of questions or information you would like to discuss with your new Primary Care Provider, including the following:

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

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

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 who specializes in treatment for your condition.

Other Providers (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 condition.

You also may decide to see a specialist without consulting your Primary Care Provider. Visit the Provider Directory, available online at www.ProvidenceHealthPlan.com, or call Customer Service to choose a specialist who is a 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 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:

- Virtual Visits (see section 4.3.2).
- E-visits (see section 4.3.3).
- Temporomandibular Joint (TMJ) Services (see section 4.12.7).
- Tobacco Use Cessation Services (see section 4.1.8).
- Human Organ/Tissue Transplants (see section 4.13).
- Any item listed in your Benefit Summary as "Not Covered" 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	Participating	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 a 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 Prior Authorization does not supersede other specific provisions of this Plan regarding coverage, limitations, exclusions and Medical Necessity.

Services received from Network Providers:
When Services are received from a Network Provider, the 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.
- All Travel Expense Reimbursement, as provided in section 3.6;
- All inpatient, residential and 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.
- 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 a 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 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 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 a 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 Maximum: 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 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/womensguidelines.

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

4.1.1 Physical Examinations and Well-Baby Care

Periodic health exams and well-baby care Services are covered in full only when received In-Network. These services are covered as stated in your Benefit Summary. Your provider will determine which tests are necessary for your physical exam according to your medical history and your current health status. More frequent exams will be covered if your provider determines that they are necessary. Vision and hearing screening services are covered when performed during a periodic health examination or well-baby care examination, 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 4.9.5.

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 Network 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 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.

- 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 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 (HbAlc) 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

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.

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

4.2.5 Women's Elective Sterilization

Coverage is provided, as stated below, for women's voluntary sterilization (tubal ligation).

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 Network facilities.

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 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 Network Providers. Not all Network Providers are contracted with us to provide Phone and Video Visits. 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 a 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 Network Providers.

4.3.3 E-visits

E-visits are covered in full and must be received from Network Providers. Not all Network Providers offer E-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-visits. Network Providers who are authorized to provide E-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-visit benefit, you must have had at least one prior office visit with your Network Provider within the last 12 months.

Covered E-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 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 email communications that do not qualify as E-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 and Injectable 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. 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 Urgent Care, call your Primary Care Provider first. Your Primary Care Provider or the provider-on-call is always available, day or night. He or she may either suggest that you 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
- Unexpected premature childbirth
- Acute abdominal pain
- Severe chest pain
- Serious burn
- Bleeding that does not stop
- Medically Necessary detoxification

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

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 care or to a facility specified by Providence Health Plan.

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 or our authorizing agent 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 a 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 or their authorizing agent.

4.5.5 Urgent Care

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

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

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 Network Provider and Providence Health Plan determine you need hospitalization, arrangements will be made for you to be admitted to a Network Hospital.

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

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

- Acute (inpatient) care;
- A semi-private room (unless a private room is Medically Necessary);
- Coronary care and intensive care;
- Isolation care; and
- Hospital services and supplies necessary for treatment and furnished by the Hospital, such as 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

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. 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 shown 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. (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 specified in section 4.11.

4.7.3 Outpatient Habilitative Services

Coverage is provided for Medically Necessary outpatient habilitative Services for maintenance, learning or improving skills and function for daily living. 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 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, 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* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within time frames outlined in Newborn Eligibility and Enrollment, section 8.2.4.

*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. (See section 8.2.4 regarding newborn eligibility and enrollment.)

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

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

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-Network.

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

Benefits for medical supplies, medical appliances, prosthetic and orthotic devices, Durable Medical Equipment (DME) and hearing aids 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, lancets and test strips, may be purchased through Providence Health Plan Network medical supply providers or under this benefit at Network Pharmacies. Unless there is a medical exception on file, diabetes test strips are limited to products listed on the pharmacy formulary and are restricted to 100 test strips per month for insulin dependent Members and 100 test strips every three months for non-insulin dependent Members. See section 4.9.4 for coverage of diabetic equipment such as glucometers and 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 additional to any Copayment or Coinsurance for the procedure.
6. Other Medically Necessary appliances 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 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).

4.9.5 Hearing Aids and Hearing Exams

Medically Necessary external hearing aids and devices, one per ear per every four calendar years, as prescribed, fitted, and dispensed by a licensed audiologist or a hearing aid/instrument specialist, are covered under this Plan. “Hearing aids and devices” are defined as any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries and cords.

Office visits for routine hearing exams and tests, including those related to the evaluation/fitting of a hearing aid, will be payable under this Plan at the office visit benefit level as shown in your Benefit Summary.

4.9.6 Wigs

The Plan will provide coverage for one synthetic wig every calendar year for Members who have undergone chemotherapy or radiation therapy 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.

4.10 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, and day, intensive outpatient, or partial hospitalization Services. All inpatient, residential, and 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 or our authorizing agent;
- 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, neurofeedback, 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 or our authorizing agent, 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, and day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan or their authorizing agent.

Prior Authorization is required for all inpatient, residential, and 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.

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 or 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 trauma, infection or other diseases and for congenital deformities and anomalies if there is a resultant functional impairment. 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 pain, or restoring facial configuration or functions such as speech, swallowing or chewing. 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 malocclusion of the 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 shorten or lengthen the upper or lower jaw, unless related to a traumatic injury or to a neoplastic or degenerative disease; and
- Services to treat temporomandibular joint syndrome, except as provided in section 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 a 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-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 Network 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 Men's Elective Sterilization Services

Covered Services include men's voluntary sterilization (vasectomy). All Covered Services must be received from Qualified Providers and Facilities. Services are covered subject to the provisions of the applicable benefit, e.g., your Outpatient Surgery benefit. Services to reverse a prior sterilization procedure are not covered.

***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.

4.12.13 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. 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.

4.13 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 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 Deductible, Coinsurance, and Copayment provisions of this Plan are waived, except as follows:

The Member/recipient is responsible for the Deductible, Coinsurance or Copayment amounts, as shown in the Benefit Summary, for inpatient Hospital Services and for outpatient facility Services that are not billed as a global fee and those amounts 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 Network 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 Network Pharmacy.

You have broad access to over 26,000 Network Pharmacies and their services at discounted rates.

Providence Health Plan Network 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.

Network Pharmacies are designated as retail, preferred retail, specialty and mail-order Pharmacies. To view a list of Network 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 Network 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 the 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.
- 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 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 Network 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 purchase 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 Network mail-order Pharmacies. To

find our Network 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 a Network 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 glucometers and 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 us 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 Network 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.

4.14.3 Prescription Drug Formulary

The Providence Health Plan Formulary is a list of Food and Drug Administration (FDA)-approved prescription generic, brand, and specialty 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 added to the formulary. 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.

4.14.4 Prescription Drugs

Generic and Brand-Name 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 your brand-name benefit includes a Copayment or Coinsurance, regardless of the reason or Medical Necessity, and you request a brand-name drug, 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 in 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 Network Pharmacies as required by ACA. Over-the-counter ACA preventive drugs received from Network Pharmacies will not be covered in full under the ACA preventive benefit without a written prescription from your Qualified Practitioner.

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; and
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; and
5. FDA-approved women's prescription contraceptives: up to 3-months initial dispensing, then up to 12-months subsequent dispensing at any of our Network Pharmacies.

Other dispensing limits may apply to certain medications requiring limited use, as determined by our medical policy. Prior Authorization is required for amounts exceeding any applicable medication dispensing limits.

4.14.6 Network 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 Network 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 there is a negative change in our Network mail-service or preferred retail Pharmacies, you will be notified of the change at least 30 days in advance.

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 therapeutic amount and must be purchased at a Network 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 Network 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.

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 for 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 hyperactivity in children and adults;
3. Drugs or medications prescribed that do not relate to the treatment of a covered illness or injury;
4. Drugs used for the treatment of fertility/infertility;

5. Fluoride, for Members over the age of 16 years old;
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, medications 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;
11. 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); and
20. Vaccines, immunizations and preventive medications solely for the purpose of travel, school, or work.

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 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 self-administered (except as provided in section 4.12.8), are prescribed by you for your own benefit, or are provided or prescribed by a person who resides in your home or is a member of your family. “Member of your family” for this purpose means any person who could possibly inherit from you under the intestate succession law of any state, plus any in-law, step relative, foster parent, or domestic partner of you or of any such person;
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos and books, educational programs to which drivers are referred by the judicial system, and volunteer mutual support groups;
- Are provided to yield primarily educational outcomes. 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;
- 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 disputed 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, 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;
- 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); and
- Relate to participation in a civil revolution or riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.

The Plan does not cover:

- Charges that are in excess of Usual, Customary and Reasonable (UCR) costs;
- Custodial Care;
- Transplants, except as provided in section 4.13;
- Services for Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, Durable Medical Equipment (DME) and Hearing Aids, 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;
- 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 and 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 unless approved by us in advance.
- Conditions for mental and nervous conditions that are specified as excluded in section 15. Definitions, for Mental Health and Substance Abuse;
- 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, 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; 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 services for the treatment of infertility, including all services related to surrogate parenting. For the purpose of this exclusion, infertility is defined as the inability to become pregnant after a year of unprotected intercourse or the inability to carry a pregnancy to term as evidenced by three consecutive spontaneous abortions;
- 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;
- Condoms and other over-the-counter birth control products; 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 parts or batteries;
- Replacement of lost or broken hearing aids;
- Repair of hearing aids are not covered. Repair needs should be discussed with your provider via your warranty period;
- Hearing aids prescribed and ordered prior to coverage, or prescribed or ordered after termination of coverage, whichever occurs first;
- Bone anchored hearing aids; and
- Hearing aids, hearing therapies and/or devices, except as provided in section 4.9.5.

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 provided 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 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 notify the provider and the provider will have 45 days to submit the additional information. Within two days of receipt of the additional information, Providence Health Plan will complete their review and notify your provider or you of their decision. If the information is not received within 45 days, the request will be denied.
- **For 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 services that involve 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 may 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 743.847, 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

Mental Health and Substance Abuse claims should be submitted to:

PBH
PO Box 30602
Salt Lake City, UT 84130

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.

B.

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.

C. 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.

D. 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.

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

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

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.

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 Network Providers or payment for Services by Out-of-Network Providers, please ask for Providence Health Plan's help. Customer Service 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;
- Imposition of a pre-existing condition exclusion, source-of injury exclusion, network exclusion, Annual benefit limit or other limitation on otherwise Covered Services;
- Determination that a health care item or service is 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 consent 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, upon request and free of charge, have reasonable access to and copies of the documents and records, and other information relevant to our decision, including the specific internal rule, guideline, protocol, or other criterion relied upon to make an Adverse Benefit Determination.
- You can be represented by anyone of your choice at all levels of 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 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 that 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 Voluntary Second Level Internal Appeal

If you are not satisfied with the decision of the internal Appeal 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, or (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care, you may request a voluntary second level internal Appeal. If your case is eligible, it will be reviewed by Providence Health Plan's Grievance Committee. The members of the Grievance Committee are made up of individuals not involved in the initial decision to uphold an Appeal. You must submit your written request for the voluntary second level internal Appeal within 60 days of the date on the internal Grievance or Appeal decision notice or that initial decision will become final. The Grievance Committee will review all documentation presented by you and send a written explanation of its decision within 30 days of receiving your request for the voluntary second level internal Appeal.

7.2.4 External Review

If you are not satisfied with the internal Grievance or Appeal decision or the decision of the voluntary second level internal Appeal 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, or (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care, 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 voluntary second level internal 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, or (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care.**

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.**

7.2.5 How to Submit Grievances or Appeals and Request Appeal Documents

To submit your Grievance or Appeal, 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 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 on this Plan. You and your Employer must provide us 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 Employee Services.

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 Employee Services.

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 his or her Spouse or Domestic Partner may elect continuation coverage for all covered Family Members. In addition, each Family Member has an independent right to elect COBRA. Thus, a Family Member may elect continuation coverage even if the 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 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 his or her covered Family Members may continue for up to 29 months from the date of the original qualifying event, or loss of coverage, whichever is later. The 29-month period applies only if the following conditions are met:

- The Social Security Administration (SSA) determines that the qualified beneficiary is disabled at any time prior to the qualifying event or during the first 60 days of COBRA continuation coverage; and
- The qualified beneficiary provides 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 that has no exclusions or limitations with respect to any pre-existing conditions. If the other plan has applicable exclusions or limitations, the COBRA continuation coverage will terminate after the exclusion or limitation no longer applies'
- The qualified beneficiary (employee, spouse, or dependent child) later becomes entitled to Medicare;
- The earliest date that the qualified beneficiary no longer qualifies for such coverage in accordance with the federal COBRA regulations; or
- The applicable maximum period of continuation coverage occurs.

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 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 NONWAIVER

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
Risk & Benefit 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 his/her 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 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**.**

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 a 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 to pay 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.

Director

Director means the director of the Oregon Department of Consumer and Business Services.

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.

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. Coverage is effective on the earlier of the first day of the next month following the completion of the Eligibility Waiting Period. 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.
5. Effective Date of Coverage: 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 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.

3. 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.

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.

E-visit

E-visit (electronic provider communications) means a consultation through email with a Network Provider that is, in the judgment of the Network Provider, Medically Necessary and appropriate and involves a significant amount of the Network Provider's time. An E-visit must relate to the treatment of a covered illness or injury (see also section 4.1.3).

Exclusion

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

Experimental/Investigational

Experimental/Investigational means those Services that are determined by Providence Health Plan not to be Medically Necessary or accepted medical practice in the Service Area, including Services performed for research purposes. In determining whether Services are Experimental/Investigational, Providence Health Plan will consider whether the Services are in general use in the medical community in the U.S.; whether the Services are under continued scientific testing and research; whether the Services show a demonstrable benefit for a particular illness or disease; whether they are proven to be safe and efficacious; and whether they are approved for use by appropriate governmental agencies. Providence Health Plan determines on a case-by-case basis whether the requested Services will result in greater benefits than other generally available Services, and will not approve such a request if the Service poses a significant risk to the health and safety of the Member. Providence Health Plan will retain documentation of the criteria used to define a Service deemed to be 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.

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).

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

1. The Service is medically indicated according to the following factors:
    a. The Service is necessary to diagnose or to meet the reasonable health needs of the Member;
    b. The expected health benefits from the Service are clinically significant and exceed the expected health risks by a significant margin;
    c. The Service is of demonstrable value and that value is superior to other Services and to the provision of no Services; and

d. Expected health benefits can include:
    - Increased life expectancy;
    - Improved functional capacity;
    - Prevention of complications; or
    - Relief of pain.

2. The Qualified Practitioner recommends the Service.
3. The Service is rendered in the most cost-efficient manner and type of setting consistent with nationally recognized standards of care, with consideration for potential benefits and harms to the patient.
4. The Service is consistent in type, frequency and duration with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by Providence Health Plan.

In the case of a life-threatening illness, a Service that would not meet the criteria above may be considered Medically Necessary for purposes of reimbursement, if:

- It is considered to be safe and effective as demonstrated by accepted clinical evidence reported by generally-recognized medical professionals or publications; and
- The treatment is provided in a clinically controlled research setting using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health for a life-threatening condition.

For the purpose of this exception, the term "life-threatening" means more likely than not to cause death within one year of the date of the request for diagnosis or treatment.

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.

Network 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 Network Pharmacies:

1. Retail: a Network Pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions.
2. Preferred Retail: a Network 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 Network 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 Network Pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.

Network Provider

Participating 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 a Network Provider.

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.

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 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 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 a Network Provider, UCR means charges based on the fee that Providence Health Plan has negotiated with 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 prevalent or which would not be considered excessive in a particular case because of unusual circumstances; or
4. 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 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 a 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 a 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: (TTY: 711).

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

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

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

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

توجه: اگر به فارسی زبان بهای رایگان به صورت زبانی تسهیلات کمکی، می‌توانید. شما 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, 2018.

By: _____

Printed Name: _____

Title: _____

Company: _____

Date: _____

MISSION

As people of Providence,
we reveal God's love for all,
especially the poor and vulnerable,
through our compassionate service.

OUR CORE VALUES

Respect, Compassion, Justice,
Excellence, Stewardship

Administered by:

Customer Service: 503-574-7500 or 800-878-4445

Sales: 503-574-6300 or 877-245-4077

www.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.

CLACKAMAS COUNTY PEACE OFFICERS ASSOCIATION
PERSONAL OPTION GRANDFATHERED PLAN

SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

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 Employee Services: 503-655-8459

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) www.ProvidenceHealthPlan.com
Mail order prescription drug services	www.ProvidenceHealthPlan.com
Medical Prior Authorization requests	800-638-0449 (toll-free)
Mental Health / Substance Abuse Prior Authorization	800-711-4577 (toll-free)
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
LifeBalance	503-234-1375 888-754-LIFE (toll-free) www.LifeBalanceProgram.com

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 Participating Providers; and
    - Providence Health Plan's national network of Participating Providers.
- Covered Services must be obtained from Participating 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 Participating Providers in our Service Area is available at http://phppd.providence.org/. 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'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 PERSONAL OPTION GRANDFATHERED PLAN

Your Plan allows you to receive Covered Services from Participating 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 a Participating Provider.

If you are unsure about a physician/provider's, Hospital's or other facility's participation with Providence Health Plan, visit the Provider Directory, available online at http://phppd.providence.org/, before you make an appointment. You also can call Customer Service to get information about a provider's participation with Providence Health Plan and your benefits.

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 Participating Providers, available online at http://phppd.providence.org/. 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** through our automated voice-recognition phone as well as 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 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.

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.

2.8 PRIVACY OF MEMBER INFORMATION

At Providence Health Plan, we respect the privacy and confidentiality of your protected health information (PHI). Providence Health Plan takes great care to determine when it is appropriate to share your PHI, in accordance with federal and state privacy laws. Providence Health Plan may use protected health information and may share it with others as part of your treatment, payment for your treatment, and our business operations.

The following are ways Providence Health Plan may use or share information about you, consistent with law:

- We will use the information to administer your benefits and help pay your medical bills that have been submitted to us for payment.
- We may share your information with your doctors or Hospitals to help them provide medical care to you (e.g., if you are in the Hospital, we may give them access to any medical records sent to us by your doctor).
- We may use or share your information with others to help manage your health care (e.g., we might talk to your doctor to suggest a disease management or wellness program that could help improve your health).
- We may share your information with individuals who perform business functions for us. We will only share your information if there is a business need to do so and if our business partner agrees to protect the information.
- We may use your information to provide you with information about alternative medical treatments and programs or about health related products and services that you may be interested in (e.g., we sometimes send out newsletters that let you know about "healthy living" alternatives such as smoking cessation or weight loss programs).

Providence Health Plan makes every effort to release only the minimum amount of information necessary to meet any release requirement and only release information on a need to know basis. Also, wherever feasible, identifiable information is removed from any information shared.

To secure the confidentiality of medical information, Providence Health Plans has procedures in place which you can review at www.ProvidenceHealthPlan.com/privacy.

When Member information is used in health studies, identifiable information is not released. All Member-specific information has identifying information removed, and aggregated data are used as early in the measurement process as possible. The privacy of our Members is completely protected.

Our agreements with Network Providers contain confidentiality provisions that require providers treat your personal health information with the same care.

You have the right to ask us to restrict how we use or disclose your information for treatment, payment or health care operations. You also have the right to ask us to restrict information we may give to persons involved in your care. While we may honor your request for restrictions, we are not required to agree to these restrictions. You have the right to ask us to redirect and send your own personal protected health information to you only and directly as permitted by current privacy laws. You also have the right to register a complaint if you believe your privacy is compromised in any manner.

Members may request to see their medical records. Call your physician's or provider's office to ask how to schedule a visit for this purpose.

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

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. Although allowable by HIPAA, Providence Health Plan's practice is to deidentify, or masks personal identifiers, on claims data released for these purposes.

In all other circumstances, Providence Health Plan does not disclose a Member's PHI to an employer or any agent of the Employer, Should Providence Health Plan change this practice, a Member's PHI would not be released to an Employer or any agent of the Employer unless Providence Health Plan determines that such disclosure is:

1. In compliance with the applicable provisions of HIPAA; and
2. 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, under which the Employer agrees to limit further disclosures to those permitted by law and plan documents, to ensure that any person or subcontractor with whom the PHI is disclosed makes similar agreements, not to use PHI for employment-related actions or decisions, not to use PHI for purposes related to any other benefits, to provide access to individuals to their PHI except as limited by law, to amend PHI as provided by law, to account for access to and disclosures of PHI as provided by law, to provide Providence Health Plan information Providence Health Plan may need to provide individuals with accountings of disclosures, to be audited by the US Department of Health & Human Services as to its handling of PHI, to return all PHI to Providence Health Plan when no longer required, to identify employees or classes of employees that need access to PHI and to prevent access to PHI for employees or classes of employees who are not identified as needing access to PHI, and to report to Providence Health Plan any violations of these principles. An Employer who receives PHI from Providence Health Plan must maintain policies and procedures that demonstrate compliance with the foregoing expectations, including procedures for the return, destruction and restriction of further use of PHI, and procedures for taking action if employees or subcontractor's inappropriately use or disclose PHI.

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. Providence Health Plan will only use or disclose a Member's PHI for treatment purposes, operational purposes, payment purposes, or for any reasonable purposes to which the Member has consented.

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 NETWORK PROVIDERS

Providence Health Plan has contractual arrangements with certain physicians/providers, hospitals and facilities located in Oregon and southwest Washington, as well as Nationwide. Our agreements with these "Network Providers" enable you to receive quality health care for a reasonable cost.

For Services to be covered, you must receive Services from Network Providers. It is your responsibility to verify whether or not a physician/provider, hospital or other facility is participating with us even if you have been directed or referred for care by a Network Provider.

3.1.1 Nationwide Network of 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 Network Providers, even when you are outside of Oregon and southwest Washington.

3.1.2 Choosing a Network Provider

To choose a Network Provider, or to verify if a provider is a Network Provider, please refer to the Provider Directory, available online at http://phppd.providence.org/. If you do not have access to our website, please call Customer Service to request Network Provider Information.

> Your 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 a 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 a 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: 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 Network Providers with the specialties listed above are Network Primary Care Providers. Please refer to the Provider Directory, available online, for a listing of designated Network Primary Care Providers or call your Customer Service team to request a hard copy.

3.2.2 Established Patients with Primary Care Providers

If you and your family already see a provider, you may want to check the provider directory to see if your provider is a Network Primary Care Provider for Providence Health Plan. If your provider is participating with us, let his or her 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 he or she is accepting new patients. It is a good idea to have your previous physician or provider transfer your medical records to your new Primary Care Provider as soon as possible. The first time you make an appointment with your Primary Care Provider, let him or her know you are now a Providence Health Plan Member. On your first visit, make a list of questions or information you would like to discuss with your new Primary Care Provider, including the following:

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

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

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 who specializes in treatment for your condition.

Other Providers (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 condition.

You also may decide to see a specialist without consulting your Primary Care Provider. Visit the Provider Directory, available online at http://phppd.providence.org/, or call Customer Service to choose a specialist who is a 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 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	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 Network Pharmacies (see section 4.14.1)**.** A list of our Network Pharmacies is available online at www.ProvidenceHealthPlan.com. You also may contact Customer Service if you need help locating a Network 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 a 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 Prior Authorization does not supersede other specific provisions of this Plan regarding coverage, limitations, exclusions and Medical Necessity.

Services received from Network Providers:
When Services are received from a Network Provider, the 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.
- All Travel Expense Reimbursement, as provided in section 3.8;
- All inpatient, residential and 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.
- 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.

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 a 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 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 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. If your Approved Clinical Trial is available through both Network and Out-of-Network providers, the Plan will require you to participate through a 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.

3.12 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.

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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 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 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/womensguidelines.

Note: Additional Plan provisions apply to some Services (e.g., routine physical examinations and well-baby care must be received from a 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 a 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, including all Services related to the examination and fitting of hearing aids; except as specified in section 4.9.5.

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 Network 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 (HbAlc) 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 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 Network Providers and Facilities. Oral contraceptives must be purchased at Network Pharmacies.

4.2.5 Women's Elective Sterilization

Coverage is provided, as stated below, for women's voluntary sterilization (tubal ligation).

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.

4.3 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 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 Network Providers. Not all Network Providers are contracted with us to provide Phone and Video Visits. 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-visits

E-visits are covered in full and must be received from Network Providers. Not all Network Providers offer E-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-visits. Network Providers who are authorized to provide E-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-visit benefit, you must have had at least one prior office visit with your Network Provider within the last 12 months.

Covered E-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 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 email communications that do not qualify as E-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 and Injectable 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. 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 Urgent Care, call your Primary Care Provider first. Your Primary Care Provider or the provider-on-call is always available, day or night. He or she may either suggest that you 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
- Unexpected premature childbirth
- Acute abdominal pain
- Severe chest pain
- Serious burn
- Bleeding that does not stop
- Medically Necessary detoxification

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

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 care or to a facility specified by Providence Health Plan.

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 or our authorizing agent 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 a 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 or their authorizing agent.

4.5.5 Urgent Care

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

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

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 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 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

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. 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 shown 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.

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 specified in section 4.11.

See section 4.6.3 for coverage of Inpatient Rehabilitative Services.

4.7.3 Outpatient Habilitative Services

Coverage is provided for Medically Necessary outpatient habilitative Services for maintenance, learning or improving skills and function for daily living. 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 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, 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* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within time frames outlined in Newborn Eligibility and Enrollment, section 8.2.4.

*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. See section 8.2.4 regarding newborn eligibility and enrollment.

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

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

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, DURABLE MEDICAL EQUIPMENT (DME) AND STATE MANDATED HEARING AID BENEFIT

Benefits for medical supplies, medical appliances, prosthetic and orthotic devices, Durable Medical Equipment (DME) and hearing aids 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, lancets and test strips, may be purchased through Providence Health Plan Network medical supply providers at Network Pharmacies. Unless there is a medical exception on file, diabetes test strips are limited to products listed on the pharmacy formulary and are restricted to100 test strips per month for insulin dependent Members and 100 test strips every three months for non-insulin dependent Members. See section 4.9.4 for coverage of diabetic equipment such as glucometers and 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 additional to any Copayment or Coinsurance for the procedure.
6. Other Medically Necessary appliances 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 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).

4.9.5 State Mandated Hearing Aid Benefit

Medically Necessary external hearing aids and devices, one per ear, as prescribed, fitted, and dispensed by a licensed audiologist or a hearing aid/instrument specialist, are covered under this Plan for Members 18 years of age or younger, and Members 19 through 25 years of age if enrolled in secondary school or an accredited educational institution. “Hearing aids and devices” are defined as any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries and cords.

4.9.6 Wigs

The Plan will provide coverage for one synthetic wig every calendar year for Members who have undergone chemotherapy or radiation therapy 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.

4.10 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

This Plan complies with Oregon and Federal Mental Health Parity.

4.10.1Mental 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, and day, intensive outpatient, or partial hospitalization Services. All inpatient, residential, and 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 or our authorizing agent;

- 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, neurofeedback, 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 or our authorizing agent, 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, and day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan or their authorizing agent.

Prior Authorization is required for all inpatient, residential, and 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.

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 or 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 trauma, infection or other diseases and for congenital deformities and anomalies if there is a resultant functional impairment. 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 pain, or restoring facial configuration or functions such as speech, swallowing or chewing. 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 malocclusion of the 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 shorten or lengthen the upper or lower jaw, unless related to a traumatic injury or to a neoplastic or degenerative disease; and
- Services to treat temporomandibular joint syndrome, 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 a 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 Network retail or specialty Pharmacy as shown in the Benefit Summary (See section4.14).

4.12.9 Men's Elective Sterilization Services

Covered Services include men's voluntary sterilization (vasectomy). All Covered Services must be received from Qualified Providers and Facilities. Services are covered subject to the provisions of the applicable benefit, e.g., your Outpatient Surgery benefit. Services to reverse a prior sterilization procedure are not covered.

***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.

4.12.10 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. 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.

4.13 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 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 Coinsurance and Copayment provisions of this Plan are waived, except as follows:

The Member/recipient is responsible for the Coinsurance or Copayment amounts, as shown in the Benefit Summary, for inpatient Hospital Services and for outpatient facility Services that are not billed as a global fee and those amounts 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 Network 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 Network Pharmacy.

You have broad access to over 26,000 Network Pharmacies and their services at discounted rates.

Providence Health Plan Network 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.

Network Pharmacies are designated as retail, preferred retail, specialty and mail-order Pharmacies. To view a list of Network 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 Network 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 the 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.
- Network 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 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 Network 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 purchase 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 Network mail-order Pharmacies. To find our Network 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 a Network 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 glucometers and 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.ProvidenceHealth Plan.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 us 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 Network 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.

4.14.3 Prescription Drug Formulary

The Providence Health Plan Formulary is a list of Food and Drug Administration (FDA)-approved prescription generic, brand and special 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 added to the formulary. 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 your brand-name benefit includes a Copayment or Coinsurance, regardless of the reason or Medical Necessity, and you request a brand-name drug, 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 in 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; and
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; and
5. FDA-approved women's prescription contraceptives: up to 3-months initial dispensing, then up to 12-months subsequent dispensing at any of our Network Pharmacies.

Other dispensing limits may apply to certain medications requiring limited use, as determined by our medical policy. Prior Authorization is required for amounts exceeding any applicable medication dispensing limits.

4.14.6 Network 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 Network 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 there is a negative change in our Network mail-service or preferred retail Pharmacies, you will be notified of the change at least 30 days in advance.

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 therapeutic amount and must be purchased at a Network 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.

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 for you by a physician, other provider or another trained person;
2. Amphetamines and amphetamine derivatives except when used in the treatment of narcolepsy or hyperactivity in children and adults;
3. Drugs or medications prescribed that do not relate to the treatment of a covered illness or injury; ;
4. Drugs used for the treatment of fertility/infertility;
5. Fluoride, for Members over the age of 10 years old;
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, medications 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;
12. 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); and
21. Vaccines, immunizations and preventive medications solely for the purpose of travel.

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 Network Provider in your area, visit our website at http://phppd.providence.org/ 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 a 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.
- 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.
- All Women's health 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 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 self-administered (except as provided in 4.12.8), are prescribed by you for your own benefit, or are provided or prescribed by a person who resides in your home or is a member of your family. "Member of your family" for this purpose means any person who could possibly inherit from you under the intestate succession law of any state, plus any in-law, step relative, foster parent, or domestic partner of you or of any such person;
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos and books, educational programs to which drivers are referred by the judicial system, and volunteer mutual support groups;
- Are provided to yield primarily educational outcomes. 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;
- 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 disputed 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, 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;
- 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); and
- Relate to participation in a civil revolution or riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.

The Plan does not cover:

- Charges that are in excess of Usual, Customary, and Reasonable (UCR) costs;
- Custodial Care;
- Transplants, except as provided in section 4.13;
- Services for Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, Durable Medical Equipment (DME) and Hearing Aids, 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 and 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 unless approved by us in advance.
- Conditions for mental and nervous conditions that are specified as excluded in section 15. Definitions, for Mental Health and Substance Abuse;
- 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; 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; and
- Dance, poetry, music or art therapy, except as part of an approved treatment program.

Exclusions that apply to <u>Provider Services</u>:

- 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 services for the treatment of infertility, including all services related to surrogate parenting. For the purpose of this exclusion, infertility is defined as the inability to become pregnant after a year of unprotected intercourse or the inability to carry a pregnancy to term as evidenced by three consecutive spontaneous abortions;
- 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;
- Condoms and other over-the-counter birth control products; 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 parts or batteries;
- Replacement of lost or broken hearing aids;
- Repair of hearing aids are not covered. Repair needs should be discussed with your provider via your warranty period;
- Hearing aids prescribed and ordered prior to coverage, or prescribed or ordered after termination of coverage, whichever occurs first;
- Bone anchored hearing aids;
- Hearing aids, hearing therapies and/or devices, including all services related to the examination and fitting of the hearing aids, except as provided in section 4.9.5; and
- Hearing screenings and exams, except as provided in section 4.1.1.

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 provided 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 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 notify the provider and the provider will have 45 days to submit the additional information. Within two days of receipt of the additional information, Providence Health Plan will complete their review and notify your provider or you of their decision. If the information is not received within 45 days, the request will be denied.
- **For 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 services that involve 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 may 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 743.847, 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

Mental Health and Substance Abuse claims should be submitted to:

PBH
PO Box 30602
Salt Lake City, UT 84130

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.

B.

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-Plan benefits.

C. 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.

D. 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.

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

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

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.

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 Network Providers or payment for Services by Out-of-Network Providers, please ask for Providence Health Plan's help. Customer Service 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 consent 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, upon request and free of charge, have reasonable access to and copies of the documents, records, and other information relevant to Providence Health Plan's decision, including the specific internal rule, guideline, protocol, or other similar criterion relied upon to make an Adverse Benefit Determination.
- You can be represented by anyone of your choice at all levels of 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 that 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 Voluntary Second Level Internal Appeal

If you are not satisfied with the decision of the internal Appeal 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) whether an exception to the Plan's prescription drug formulary should be granted, you may request a voluntary second level internal Appeal. If your case is eligible, it will be reviewed by Providence Health Plan's Grievance Committee. The members of the Grievance Committee are individuals not involved in the initial decision to uphold an Appeal. You must submit your written request for the voluntary second level internal Appeal within 60 days of the date on the internal Grievance or Appeal decision notice or that initial decision will become final. The Grievance Committee will review all documentation presented by you and send a written explanation of its decision within 30 days of receiving your request for the voluntary second level internal Appeal.

7.2.4 External Review

If you are not satisfied with the internal Grievance or Appeal decision or the decision of the voluntary second level internal Appeal 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) whether an exception to the Plan's prescription drug formulary should be granted, 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 voluntary second level internal 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) whether an exception to the Plan's prescription drug formulary should be granted.**

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.**

7.2.5 How to Submit Grievances or Appeals and Request Appeal Documents

To submit your Grievance or Appeal, 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 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 on this Plan. You and your Employer must provide us 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 Employee Services.

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 Employee Services

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 his or her Spouse or Domestic Partner may elect continuation coverage for all covered Family Members. In addition, each Family Member has an independent right to elect COBRA. Thus, a Family Member may elect continuation coverage even if the 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 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 his or her covered Family Members may continue for up to 29 months from the date of the original qualifying event, or loss of coverage, whichever is later. The 29-month period applies only if the following conditions are met:

- The Social Security Administration (SSA) determines that the qualified beneficiary is disabled at any time prior to the qualifying event or during the first 60 days of COBRA continuation coverage; and
- The qualified beneficiary provides 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 that has no exclusions or limitations with respect to any pre-existing conditions. If the other plan has applicable exclusions or limitations, the COBRA continuation coverage will terminate after the exclusion or limitation no longer applies'
- The qualified beneficiary (employee, spouse, or dependent child) later becomes entitled to Medicare;
- The earliest date that the qualified beneficiary no longer qualifies for such coverage in accordance with the federal COBRA regulations; or
- The applicable maximum period of continuation coverage occurs.

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 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 NONWAIVER

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
Risk & Benefit 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 his/her 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 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**.**

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 a 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 to pay 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.

Director

Director means the director of the Oregon Department of Consumer and Business Services.

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.

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. Coverage is effective on the earlier of the first day of the next month following the completion of the Eligibility Waiting Period. 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.
5. Effective Date of Coverage: 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 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.

3. 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.

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.

E-visit

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

Exclusion

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

Experimental/Investigational

Experimental/Investigational means those Services that are determined by Providence Health Plan not to be Medically Necessary or accepted medical practice in the Service Area, including Services performed for research purposes. In determining whether Services are Experimental/Investigational, Providence Health Plan will consider whether the Services are in general use in the medical community in the U.S.; whether the Services are under continued scientific testing and research; whether the Services show a demonstrable benefit for a particular illness or disease; whether they are proven to be safe and efficacious; and whether they are approved for use by appropriate governmental agencies. Providence Health Plan determines on a case-by-case basis whether the requested Services will result in greater benefits than other generally available Services, and will not approve such a request if the Service poses a significant risk to the health and safety of the Member. Providence Health Plan will retain documentation of the criteria used to define a Service deemed to be 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.

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).

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

1. The Service is medically indicated according to the following factors:
    a. The Service is necessary to diagnose or to meet the reasonable health needs of the Member;
    b. The expected health benefits from the Service are clinically significant and exceed the expected health risks by a significant margin;
    c. The Service is of demonstrable value and that value is superior to other Services and to the provision of no Services; and
    d. Expected health benefits can include:
        - Increased life expectancy;
        - Improved functional capacity;
        - Prevention of complications; or
        - Relief of pain.
2. The Qualified Practitioner recommends the Service.
3. The Service is rendered in the most cost-efficient manner and type of setting consistent with nationally recognized standards of care, with consideration for potential benefits and harms to the patient.
4. The Service is consistent in type, frequency and duration with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by Providence Health Plan.

In the case of a life-threatening illness, a Service that would not meet the criteria above may be considered Medically Necessary for purposes of reimbursement, if:

- It is considered to be safe and effective as demonstrated by accepted clinical evidence reported by generally-recognized medical professionals or publications; and
- The treatment is provided in a clinically controlled research setting using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health for a life-threatening condition.

For the purpose of this exception, the term “life-threatening” means more likely than not to cause death within one year of the date of the request for diagnosis or treatment.

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).

Network Pharmacy

Network 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 Network Pharmacies:

1. Retail: a Network Pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions.
2. Preferred Retail: a Network 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 Network 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 Network Pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.

Network Provider

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 a Network Provider.

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.

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 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 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 a Network Provider, UCR means charges based on the fee that Providence Health Plan has negotiated with 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 prevalent or which would not be considered excessive in a particular case because of unusual circumstances; or
4. 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 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 a 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: (TTY: 711).

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

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

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

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

توجه: اگر به زبان فارسی گفتگو می‌کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می‌باشد. با (TTY: 711) 1-800-878-4445 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, 2018.

By: _____

Printed Name: _____

Title: _____

Company: _____

Date: _____

MISSION

As people of Providence,
we reveal God's love for all,
especially the poor and vulnerable,
through our compassionate service.

OUR CORE VALUES

Respect, Compassion, Justice,
Excellence, Stewardship

Administered by:

Customer Service: 503-574-7500 or 800-878-4445

Sales: 503-574-6300 or 877-245-4077

www.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.

CLACKAMAS COUNTY PEACE OFFICERS ASSOCIATION
OPEN OPTION GRANDFATHERED PLAN

SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

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 Employee Services: 503-655-8459

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) www.ProvidenceHealthPlan.com
Mail order prescription drug services	www.ProvidenceHealthPlan.com
Medical Prior Authorization requests	800-638-0449 (toll-free)
Mental Health / Substance Abuse Prior Authorization	800-711-4577 (toll-free)
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

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 Network Providers;
    - Providence Health Plan's national network of Network Providers; and
    - Out-of-Network Providers.
- With this Plan, Members will generally have lower out-of-pocket expenses when obtaining Covered Services from Network Providers. Members may, however, obtain most Covered Services from Non-Participating 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:
    - Virtual Visits, as specified in section 4.3.2;
    - E-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 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 Network Providers is available at http://phppd.providence.org/. 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'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 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 Network Providers. Also, 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 a Network Provider.

If you are unsure about a physician/provider's, Hospital's or other facility's participation with Providence Health Plan, visit the Provider Directory, available online at http://phppd.providence.org/, before you make an appointment. You also can call Customer Service to get information about a provider's participation with Providence Health Plan and your benefits.

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 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 Network Providers, available online at http://phppd.providence.org/. 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** through our automated voice-recognition phone as well as 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 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 section4.1.6, 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.

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*, section2.4, 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.

2.8 PRIVACY OF MEMBER INFORMATION

At Providence Health Plan, we respect the privacy and confidentiality of your protected health information (PHI). Providence Health Plan takes great care to determine when it is appropriate to share your PHI, in accordance with federal and state privacy laws. Providence Health Plan may use protected health information and may share it with others as part of your treatment, payment for your treatment, and our business operations.

The following are ways Providence Health Plan may use or share information about you, consistent with law:

- We will use the information to administer your benefits and help pay your medical bills that have been submitted to us for payment.
- We may share your information with your doctors or Hospitals to help them provide medical care to you (e.g., if you are in the Hospital, we may give them access to any medical records sent to us by your doctor).
- We may use or share your information with others to help manage your health care (e.g., we might talk to your doctor to suggest a disease management or wellness program that could help improve your health).
- We may share your information with individuals who perform business functions for us. We will only share your information if there is a business need to do so and if our business partner agrees to protect the information.
- We may use your information to provide you with information about alternative medical treatments and programs or about health related products and services that you may be interested in (e.g., we sometimes send out newsletters that let you know about “healthy living” alternatives such as smoking cessation or weight loss programs).

Providence Health Plan makes every effort to release only the minimum amount of information necessary to meet any release requirement and only release information on a need to know basis. Also, wherever feasible, identifiable information is removed from any information shared.

To secure the confidentiality of medical information, Providence Health Plans has procedures in place which you can review at www.ProvidenceHealthPlan.com/privacy.

When Member information is used in health studies, identifiable information is not released. All Member-specific information has identifying information removed, and aggregated data are used as early in the measurement process as possible. The privacy of our Members is completely protected.

Our agreements with Network Providers contain confidentiality provisions that require providers treat your personal health information with the same care.

You have the right to ask us to restrict how we use or disclose your information for treatment, payment or health care operations. You also have the right to ask us to restrict information we may give to persons involved in your care. While we may honor your request for restrictions, we are not required to agree to these restrictions. You have the right to ask us to redirect and send your own personal protected health information to you only and directly as permitted by current privacy laws. You also have the right to register a complaint if you believe your privacy is compromised in any manner.

Members may request to see their medical records. Call your physician's or provider's office to ask how to schedule a visit for this purpose.

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

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. Although allowable by HIPAA, Providence Health Plan's practice is to deidentify, or masks personal identifiers, on claims data released for these purposes.

In all other circumstances, Providence Health Plan does not disclose a Member's PHI to an employer or any agent of the Employer, Should Providence Health Plan change this practice, a Member's PHI would not be released to an Employer or any agent of the Employer unless Providence Health Plan determines that such disclosure is:

1. In compliance with the applicable provisions of HIPAA; and
2. 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, under which the Employer agrees to limit further disclosures to those permitted by law and plan documents, to ensure that any person or subcontractor with whom the PHI is disclosed makes similar agreements, not to use PHI for employment-related actions or decisions, not to use PHI for purposes related to any other benefits, to provide access to individuals to their PHI except as limited by law, to amend PHI as provided by law, to account for access to and disclosures of PHI as provided by law, to provide Providence Health Plan information Providence Health Plan may need to provide individuals with accountings of disclosures, to be audited by the US Department of Health & Human Services as to its handling of PHI, to return all PHI to Providence Health Plan when no longer required, to identify employees or classes of employees that need access to PHI and to prevent access to PHI for employees or classes of employees who are not identified as needing access to PHI, and to report to Providence Health Plan any violations of these principles. An Employer who receives PHI from Providence Health Plan must maintain policies and procedures that demonstrate compliance with the foregoing expectations, including procedures for the return, destruction and restriction of further use of PHI, and procedures for taking action if employees or subcontractor's inappropriately use or disclose PHI.

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. Providence Health Plan will only use or disclose a Member's PHI for treatment purposes, operational purposes, payment purposes, or for any reasonable purposes to which the Member has consented.

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 PARTICIPATING PROVIDERS

Providence Health Plan has contractual arrangements with certain physicians/providers, hospitals and facilities located in Oregon and southwest Washington, as well as Nationwide. Our agreements with these "Participating 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 Network Providers. It is your responsibility to verify whether or not a physician/provider, hospital or other facility is participating with us even if you have been directed or referred for care by a Network Provider.

3.1.1 Nationwide Network of 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 Network Providers, even when you are outside of Oregon and southwest Washington.

3.1.2 Choosing a Network Provider

To choose a Network Provider, or to verify if a provider is a Network Provider, please refer to the Provider Directory, available online at http://phppd.providence.org/. If you do not have access to our website, please call Customer Service to request Network Provider Information.

Advantages of Using a Network Provider

- Your 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 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 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 a Network Provider, including a 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 a 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 a 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: 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 Network Providers with the specialties listed above are Network Primary Care Providers. Please refer to the Provider Directory, available online, for a listing of designated Network Primary Care Providers or call your Customer Service team to request a hard copy.

3.2.2 Established Patients with Primary Care Providers

If you and your family already see a provider, you may want to check the provider directory to see if your provider is a Network Primary Care Provider for Providence Health Plan. If your provider is participating with us, let his or her 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 he or she is accepting new patients. It is a good idea to have your previous physician or provider transfer your medical records to your new Primary Care Provider as soon as possible. The first time you make an appointment with your Primary Care Provider, let him or her know you are now a Providence Health Plan Member. On your first visit, make a list of questions or information you would like to discuss with your new Primary Care Provider, including the following:

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

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

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 who specializes in treatment for your condition.

Other Providers (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 condition.

You also may decide to see a specialist without consulting your Primary Care Provider. Visit the Provider Directory, available online at http://phppd.providence.org/, or call Customer Service to choose a specialist who is a 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 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:

- Virtual Visits (see section 4.3.2).
- E-visits (see section 4.3.3).
- Temporomandibular Joint (TMJ) Services (see section 4.12.7).
- Tobacco Use Cessation Services (see section 4.1.8).
- Human Organ/Tissue Transplants (see section 4.13).
- Any item listed in your Benefit Summary as "Not Covered" 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	Participating	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 a 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 Prior Authorization does not supersede other specific provisions of this Plan regarding coverage, limitations, exclusions and Medical Necessity.

Services received from Network Providers:
When Services are received from a Network Provider, the 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.
- All Travel Expense Reimbursement, as provided in section 3.6;
- All inpatient, residential and 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.
- 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.

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 a 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 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 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 a 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 Maximum: 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 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/womensguidelines.

Note: Additional Plan provisions apply to some Services (e.g., routine physical examinations and well-baby care must be received from a 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 a 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, including all Services related to the examination and fitting of hearing aids; except as specified in section 4.9.5.

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 Network 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 (HbAlc) 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 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 Network Pharmacy.

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

4.2.5 Women's Elective Sterilization

Coverage is provided, as stated below, for women's voluntary sterilization (tubal ligation).

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 Network facilities.

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 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 Network Providers. Not all Network Providers are contracted with us to provide Phone and Video Visits. 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-visits

E-visits are covered in full and must be received from Network Providers. Not all Network Providers offer E-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-visits. Network Providers who are authorized to provide E-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-visit benefit, you must have had at least one prior office visit with your Network Provider within the last 12 months.

Covered E-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 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 email communications that do not qualify as E-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 and Injectable 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. 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 Urgent Care, call your Primary Care Provider first. Your Primary Care Provider or the provider-on-call is always available, day or night. He or she may either suggest that you 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
- Unexpected premature childbirth
- Acute abdominal pain
- Severe chest pain
- Serious burn
- Bleeding that does not stop
- Medically Necessary detoxification

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

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 care or to a facility specified by Providence Health Plan.

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 or our authorizing agent 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 a 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 or their authorizing agent.

4.5.5 Urgent Care

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

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

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 Network Provider and Providence Health Plan determine you need hospitalization, arrangements will be made for you to be admitted to a Network Hospital.

Out-of-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 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

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. 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 shown 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.)

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 specified in section 4.11.

4.7.3 Outpatient Habilitative Services

Coverage is provided for Medically Necessary outpatient habilitative Services for maintenance, learning or improving skills and function for daily living. 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 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, 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* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within time frames outlined in Newborn Eligibility and Enrollment, section 8.2.4.

*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. See section 8.2.4 regarding newborn eligibility and enrollment.

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

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

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, DURABLE MEDICAL EQUIPMENT (DME) AND STATE MANDATED HEARING AID BENEFIT

Benefits for medical supplies, medical appliances, prosthetic and orthotic devices, 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, lancets and test strips, may be purchased through Providence Health Plan Network medical supply providers at Network Pharmacies. Unless there is a medical exception on file, diabetes test strips are limited to products listed on the pharmacy formulary and are restricted to 100 test strips per month for insulin dependent Members and 100 test strips every three months for non-insulin dependent Members. See section 4.9.4 for coverage of diabetic equipment such as glucometers and 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 additional to any Copayment or Coinsurance for the procedure.
6. Other Medically Necessary appliances 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 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).

4.9.5 State Mandated Hearing Aid Benefit

Medically Necessary external hearing aids and devices, one per ear, as prescribed, fitted, and dispensed by a licensed audiologist or a hearing aid/instrument specialist, are covered under this Plan for Members 18 years of age or younger, and Members 19 through 25 years of age if enrolled in secondary school or an accredited educational institution. “Hearing aids and devices” are defined as any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries and cords.

4.9.6 Wigs

The Plan will provide coverage for one synthetic wig every calendar year for Members who have undergone chemotherapy or radiation therapy 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.

4.10 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

This Plan complies with Oregon and Federal Mental Health Parity.

4.10.1Mental 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, and day, intensive outpatient, or partial hospitalization Services. All inpatient, residential, and 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 or our authorizing agent;

- 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, neurofeedback, 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 or our authorizing agent, 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, and day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan or their authorizing agent.

Prior Authorization is required for all inpatient, residential, and 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.

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 or 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 trauma, infection or other diseases and for congenital deformities and anomalies if there is a resultant functional impairment. 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 pain, or restoring facial configuration or functions such as speech, swallowing or chewing. 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 malocclusion of the 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 shorten or lengthen the upper or lower jaw, unless related to a traumatic injury or to a neoplastic or degenerative disease; and
- Services to treat temporomandibular joint syndrome, 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 a 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 Network retail or specialty Pharmacy as shown in the Benefit Summary (See section 4.14).

4.12.9 Men's Elective Sterilization Services

Covered Services include men's voluntary sterilization (vasectomy). All Covered Services must be received from Qualified Providers and Facilities. Services are covered subject to the provisions of the applicable benefit, e.g., your Outpatient Surgery benefit. Services to reverse a prior sterilization procedure are not covered.

***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.

4.12.10 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. 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.

4.13 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 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 Deductible, Coinsurance, and Copayment provisions of this Plan are waived, except as follows:

The Member/recipient is responsible for the Deductible, Coinsurance or Copayment amounts, as shown in the Benefit Summary, for inpatient Hospital Services and for outpatient facility Services that are not billed as a global fee and those amounts 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 Network 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 Network Pharmacy.

You have broad access to over 26,000 Network Pharmacies and their services at discounted rates.

Providence Health Plan Network 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.

Network Pharmacies are designated as retail, preferred retail, specialty and mail-order Pharmacies. To view a list of Network 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 Network 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 the 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.
- 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 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 Network 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 purchase 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 Network mail-order Pharmacies. To find our Network 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 a Network 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 glucometers and 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 us 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 Network 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.

4.14.3 Prescription Drug Formulary

The Providence Health Plan Formulary is a list of Food and Drug Administration (FDA)-approved prescription generic, brand and specialty 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 added to the formulary. 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 your brand-name benefit includes a Copayment or Coinsurance, regardless of the reason or Medical Necessity, and you request a brand-name drug, 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 in 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; and
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; and
5. FDA-approved women's prescription contraceptives: up to 3-months initial dispensing, then up to 12-months subsequent dispensing at any of our Network Pharmacies.

Other dispensing limits may apply to certain medications requiring limited use, as determined by our medical policy. Prior Authorization is required for amounts exceeding any applicable medication dispensing limits.

4.14.6 Network 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 Network 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 there is a negative change in our Network mail-service or preferred retail Pharmacies, you will be notified of the change at least 30 days in advance.

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 therapeutic amount and must be purchased at a Network 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.

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 for you by a physician, other provider or another trained person;
2. Amphetamines and amphetamine derivatives except when used in the treatment of narcolepsy or hyperactivity in children and adults;
3. Drugs or medications prescribed that do not relate to the treatment of a covered illness or injury;
4. Drugs used for the treatment of fertility/infertility;
5. Fluoride, for Members over the age of 10 years old;
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, medications 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;
12. 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); and
21. Vaccines, immunizations and preventive medications solely for the purpose of travel.

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 Network Provider in your area, visit our website at http://phppd.providence.org/ 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 a 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.
- 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.
- All Women's health 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 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 self-administered (except as provided in 4.12.8), are prescribed by you for your own benefit, or are provided or prescribed by a person who resides in your home or is a member of your family. "Member of your family" for this purpose means any person who could possibly inherit from you under the intestate succession law of any state, plus any in-law, step relative, foster parent, or domestic partner of you or of any such person;
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos and books, educational programs to which drivers are referred by the judicial system, and volunteer mutual support groups;
- Are provided to yield primarily educational outcomes. 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;
- 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 disputed 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, 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;
- 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); and
- Relate to participation in a civil revolution or riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.

The Plan does not cover:

- Charges that are in excess of Usual, Customary, and Reasonable (UCR) costs;
- Custodial Care;
- Transplants, except as provided in section 4.13;
- Services for Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, Durable Medical Equipment (DME) and Hearing Aids, 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 and 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 unless approved by us in advance.
- Conditions for mental and nervous conditions that are specified as excluded in section 15. Definitions, for Mental Health and Substance Abuse;
- 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; 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; and
- Dance, poetry, music or art therapy, except as part of an approved treatment program.

Exclusions that apply to <u>Provider Services</u>:

- 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 services for the treatment of infertility, including all services related to surrogate parenting. For the purpose of this exclusion, infertility is defined as the inability to become pregnant after a year of unprotected intercourse or the inability to carry a pregnancy to term as evidenced by three consecutive spontaneous abortions;
- 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;
- Condoms and other over-the-counter birth control products; 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 parts or batteries;
- Replacement of lost or broken hearing aids;
- Repair of hearing aids are not covered. Repair needs should be discussed with your provider via your warranty period;
- Hearing aids prescribed and ordered prior to coverage, or prescribed or ordered after termination of coverage, whichever occurs first;
- Bone anchored hearing aids;
- Hearing aids, hearing therapies and/or devices, including all services related to the examination and fitting of the hearing aids, except as provided in section 4.9.5; and
- Hearing screenings and exams, except as provided in section 4.1.1.

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 provided in section 4.9.2.

Exclusions that apply to <u>Prescription Drugs, Medicines and Devices</u>:

- 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 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 notify the provider and the provider will have 45 days to submit the additional information. Within two days of receipt of the additional information, Providence Health Plan will complete their review and notify your provider or you of their decision. If the information is not received within 45 days, the request will be denied.
- **For 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 services that involve 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 may 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 743.847, 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

Mental Health and Substance Abuse claims should be submitted to:

PBH
PO Box 30602
Salt Lake City, UT 84130

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.

B.

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-Plan benefits.

C. 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.

D. 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.

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

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

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.

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 Network Providers or payment for Services by Out-of-Network Providers, please ask for Providence Health Plan's help. Customer Service 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 consent 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, upon request and free of charge, have reasonable access to and copies of the documents, records, and other information relevant to Providence Health Plan's decision, including the specific internal rule, guideline, protocol, or other similar criterion relied upon to make an Adverse Benefit Determination.
- You can be represented by anyone of your choice at all levels of 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 that 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 Voluntary Second Level Internal Appeal

If you are not satisfied with the decision of the internal Appeal 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, or (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care, you may request a voluntary second level internal Appeal. If your case is eligible, it will be reviewed by Providence Health Plan's Grievance Committee. The members of the Grievance Committee are individuals not involved in the initial decision to uphold an Appeal. You must submit your written request for the voluntary second level internal Appeal within 60 days of the date on the internal Grievance or Appeal decision notice or that initial decision will become final. The Grievance Committee will review all documentation presented by you and send a written explanation of its decision within 30 days of receiving your request for the voluntary second level internal Appeal.

7.2.4 External Review

If you are not satisfied with the internal Grievance or Appeal decision or the decision of the voluntary second level internal Appeal 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) whether an exception to the Plan's prescription drug formulary should be granted, 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 voluntary second level internal 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) whether an exception to the Plan's prescription drug formulary should be granted.**

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.**

7.2.5 How to Submit Grievances or Appeals and Request Appeal Documents

To submit your Grievance or Appeal, 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 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 on this Plan. You and your Employer must provide us 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 Employee Services
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 Employee Services .

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 his or her Spouse or Domestic Partner]may elect continuation coverage for all covered Family Members. In addition, each Family Member has an independent right to elect COBRA. Thus, a Family Member may elect continuation coverage even if the 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 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 his or her covered Family Members may continue for up to 29 months from the date of the original qualifying event, or loss of coverage, whichever is later. The 29-month period applies only if the following conditions are met:

- The Social Security Administration (SSA) determines that the qualified beneficiary is disabled at any time prior to the qualifying event or during the first 60 days of COBRA continuation coverage; and
- The qualified beneficiary provides 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 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 section11.2) 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 NONWAIVER

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
Risk & Benefit 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 his/her 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 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**.**

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 a 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 to pay 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.

Director

Director means the director of the Oregon Department of Consumer and Business Services.

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.

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. Coverage is effective on the earlier of the first day of the next month following the completion of the Eligibility Waiting Period. 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.
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 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.

3. 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.

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.

E-visit

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

Exclusion

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

Experimental/Investigational

Experimental/Investigational means those Services that are determined by Providence Health Plan not to be Medically Necessary or accepted medical practice in the Service Area, including Services performed for research purposes. In determining whether Services are Experimental/Investigational, Providence Health Plan will consider whether the Services are in general use in the medical community in the U.S.; whether the Services are under continued scientific testing and research; whether the Services show a demonstrable benefit for a particular illness or disease; whether they are proven to be safe and efficacious; and whether they are approved for use by appropriate governmental agencies. Providence Health Plan determines on a case-by-case basis whether the requested Services will result in greater benefits than other generally available Services, and will not approve such a request if the Service poses a significant risk to the health and safety of the Member. Providence Health Plan will retain documentation of the criteria used to define a Service deemed to be 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.

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).

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

1. The Service is medically indicated according to the following factors:
    a. The Service is necessary to diagnose or to meet the reasonable health needs of the Member;
    b. The expected health benefits from the Service are clinically significant and exceed the expected health risks by a significant margin;
    c. The Service is of demonstrable value and that value is superior to other Services and to the provision of no Services; and
    d. Expected health benefits can include:
        - Increased life expectancy;
        - Improved functional capacity;
        - Prevention of complications; or
        - Relief of pain.
2. The Qualified Practitioner recommends the Service.
3. The Service is rendered in the most cost-efficient manner and type of setting consistent with nationally recognized standards of care, with consideration for potential benefits and harms to the patient.
4. The Service is consistent in type, frequency and duration with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by Providence Health Plan.

In the case of a life-threatening illness, a Service that would not meet the criteria above may be considered Medically Necessary for purposes of reimbursement, if:

- It is considered to be safe and effective as demonstrated by accepted clinical evidence reported by generally-recognized medical professionals or publications; and
- The treatment is provided in a clinically controlled research setting using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health for a life-threatening condition.

For the purpose of this exception, the term "life-threatening" means more likely than not to cause death within one year of the date of the request for diagnosis or treatment.

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).

Network 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 Network Pharmacies:

1. Retail: a Network Pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions.
2. Preferred Retail: a Network 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 Network 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 Network Pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.

Network Provider

Participating 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 a Network Provider.

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.

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 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 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 a Network Provider, UCR means charges based on the fee that Providence Health Plan has negotiated with 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 prevalent or which would not be considered excessive in a particular case because of unusual circumstances; or
4. 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 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 a 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: (TTY: 711).

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

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

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

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

توجه: اگر به زبان فارسی گفتگو می‌شود، تسهیلات زبانی بصورت رایگان برای شما فراهم می‌باشد. 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, 2018.

By: _____

Printed Name: _____

Title: _____

Company: _____

Date: _____

MISSION

As people of Providence,
we reveal God's love for all,
especially the poor and vulnerable,
through our compassionate service.

OUR CORE VALUES

Respect, Compassion, Justice,
Excellence, Stewardship

Administered by:

Customer Service: 503-574-7500 or 800-878-4445

Sales: 503-574-6300 or 877-245-4077

www.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.

CLACKAMAS COUNTY
EARLY RETIREES ▪ COBRA PARTICIPANTS ▪ TEMPORARY EMPLOYEES
OPEN OPTION PLAN

SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

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 Employee Services: 503-655-8459

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) www.ProvidenceHealthPlan.com
Mail order prescription drug services	www.ProvidenceHealthPlan.com
Medical Prior Authorization requests	800-638-0449 (toll-free)
Mental Health / Substance Abuse Prior Authorization	800-711-4577 (toll-free)
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
LifeBalance	503-234-1375 888-754-LIFE (toll free) www.LifeBalanceProgram.com

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 Network Providers;
    - Providence Health Plan's national network of Network Providers; and
    - Out-of-Network Providers.
- With this Plan, Members will generally have lower out-of-pocket expenses when obtaining Covered Services from 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:
    - Virtual Visits, as specified in section 4.3.2;
    - E-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-Network.
- Coverage is provided in full for most preventive Services when those Services are received from specified 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 Network Providers is available at http://phppd.providence.org/. 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 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 Network Providers. Also, 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 a Network Provider.

If you are unsure about a physician/provider's, Hospital's or other facility's participation with Providence Health Plan, visit the Provider Directory, available online at http://phppd.providence.org/, before you make an appointment. You also can call Customer Service to get information about a provider's participation with Providence Health Plan and your benefits.

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 Network Providers, available online at http://phppd.providence.org/. 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** through our automated voice-recognition phone as well as 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 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.

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.

2.8 PRIVACY OF MEMBER INFORMATION

At Providence Health Plan, we respect the privacy and confidentiality of your protected health information (PHI). Providence Health Plan takes great care to determine when it is appropriate to share your PHI, in accordance with federal and state privacy laws. Providence Health Plan may use protected health information and may share it with others as part of your treatment, payment for your treatment, and our business operations.

The following are ways Providence Health Plan may use or share information about you, consistent with law:

- We will use the information to administer your benefits and help pay your medical bills that have been submitted to us for payment.
- We may share your information with your doctors or Hospitals to help them provide medical care to you (e.g., if you are in the Hospital, we may give them access to any medical records sent to us by your doctor).
- We may use or share your information with others to help manage your health care (e.g., we might talk to your doctor to suggest a disease management or wellness program that could help improve your health).
- We may share your information with individuals who perform business functions for us. We will only share your information if there is a business need to do so and if our business partner agrees to protect the information.
- We may use your information to provide you with information about alternative medical treatments and programs or about health related products and services that you may be interested in (e.g., we sometimes send out newsletters that let you know about “healthy living” alternatives such as smoking cessation or weight loss programs).

Providence Health Plan makes every effort to release only the minimum amount of information necessary to meet any release requirement and only release information on a need to know basis. Also, wherever feasible, identifiable information is removed from any information shared.

To secure the confidentiality of medical information, Providence Health Plans has procedures in place which you can review at www.ProvidenceHealthPlan.com/privacy.

When Member information is used in health studies, identifiable information is not released. All Member-specific information has identifying information removed, and aggregated data are used as early in the measurement process as possible. The privacy of our Members is completely protected.

Our agreements with Network Providers contain confidentiality provisions that require providers treat your personal health information with the same care.

You have the right to ask us to restrict how we use or disclose your information for treatment, payment or health care operations. You also have the right to ask us to restrict information we may give to persons involved in your care. While we may honor your request for restrictions, we are not required to agree to these restrictions. You have the right to ask us to redirect and send your own personal protected health information to you only and directly as permitted by current privacy laws. You also have the right to register a complaint if you believe your privacy is compromised in any manner.

Members may request to see their medical records. Call your physician's or provider's office to ask how to schedule a visit for this purpose.

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

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. Although allowable by HIPAA, Providence Health Plan's practice is to deidentify, or masks personal identifiers, on claims data released for these purposes.

In all other circumstances, Providence Health Plan does not disclose a Member's PHI to an employer or any agent of the Employer, Should Providence Health Plan change this practice, a Member's PHI would not be released to an Employer or any agent of the Employer unless Providence Health Plan determines that such disclosure is:

1. In compliance with the applicable provisions of HIPAA; and
2. 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, under which the Employer agrees to limit further disclosures to those permitted by law and plan documents, to ensure that any person or subcontractor with whom the PHI is disclosed makes similar agreements, not to use PHI for employment-related actions or decisions, not to use PHI for purposes related to any other benefits, to provide access to individuals to their PHI except as limited by law, to amend PHI as provided by law, to account for access to and disclosures of PHI as provided by law, to provide Providence Health Plan information Providence Health Plan may need to provide individuals with accountings of disclosures, to be audited by the US Department of Health & Human Services as to its handling of PHI, to return all PHI to Providence Health Plan when no longer required, to identify employees or classes of employees that need access to PHI and to prevent access to PHI for employees or classes of employees who are not identified as needing access to PHI, and to report to Providence Health Plan any violations of these principles. An Employer who receives PHI from Providence Health Plan must maintain policies and procedures that demonstrate compliance with the foregoing expectations, including procedures for the return, destruction and restriction of further use of PHI, and procedures for taking action if employees or subcontractor's inappropriately use or disclose PHI.

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. Providence Health Plan will only use or disclose a Member's PHI for treatment purposes, operational purposes, payment purposes, or for any reasonable purposes to which the Member has consented.

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 NETWORK PROVIDERS

Providence Health Plan has contractual arrangements with certain physicians/providers, hospitals and facilities located in Oregon and southwest Washington, as well as Nationwide. Our agreements with these "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 Network Providers. It is your responsibility to verify whether or not a physician/provider, hospital or other facility is participating with us even if you have been directed or referred for care by a Network Provider.

3.1.1 Nationwide Network of 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 Network Providers, even when you are outside of Oregon and southwest Washington.

3.1.2 Choosing a Network Provider

To choose a Network Provider, or to verify if a provider is a Network Provider, please refer to the Provider Directory, available online at http://phppd.providence.org/. If you do not have access to our website, please call Customer Service to request Network Provider Information.

Advantages of Using a Network Provider

- Your 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 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 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 a Network Provider, including a 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 a 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 a 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: 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 Network Providers with the specialties listed above are Network Primary Care Providers. Please refer to the Provider Directory, available online, for a listing of designated Network Primary Care Providers or call your Customer Service team to request a hard copy.

3.2.2 Established Patients with Primary Care Providers

If you and your family already see a provider, you may want to check the provider directory to see if your provider is a Network Primary Care Provider for Providence Health Plan. If your provider is participating with us, let his or her 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 he or she is accepting new patients. It is a good idea to have your previous physician or provider transfer your medical records to your new Primary Care Provider as soon as possible. The first time you make an appointment with your Primary Care Provider, let him or her know you are now a Providence Health Plan Member. On your first visit, make a list of questions or information you would like to discuss with your new Primary Care Provider, including the following:

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

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

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 who specializes in treatment for your condition.

Other Providers (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 condition.

You also may decide to see a specialist without consulting your Primary Care Provider. Visit the Provider Directory, available online at http://phppd.providence.org/, or call Customer Service to choose a specialist who is a 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 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:

- Virtual Visits (see section 4.3.2).
- E-visits (see section 4.3.3).
- Temporomandibular Joint (TMJ) Services (see section 4.12.7).
- Tobacco Use Cessation Services (see section 4.1.8).
- Human Organ/Tissue Transplants (see section 4.13).
- Any item listed in your Benefit Summary as "Not Covered" 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	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 a 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 Prior Authorization does not supersede other specific provisions of this Plan regarding coverage, limitations, exclusions and Medical Necessity.

Services received from Network Providers:
When Services are received from a Participating Provider, the 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.
- All Travel Expense Reimbursement, as provided in section 3.6;
- All inpatient, residential and 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.
- 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 a 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 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 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 a 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 Maximum: 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 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/womensguidelines.

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

4.1.1 Physical Examinations and Well-Baby Care

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

Hearing aids, including all Services related to the examination and fitting of hearing aids; except as specified in section 4.9.5.

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 Network 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-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 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 (HbAlc) 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

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.

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

4.2.5 Women's Elective Sterilization

Coverage is provided, as stated below, for women's voluntary sterilization (tubal ligation).

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 Network facilities.

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 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 Network Providers. Not all Network Providers are contracted with us to provide Phone and Video Visits. Network Providers who are authorized to provide Phone and Video Visits have agreed to use Internet security 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 a 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 Network Providers.

4.3.3 E-visits

E-visits are covered in full and must be received from Network Providers. Not all Network Providers offer E-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-visits. Network Providers who are authorized to provide E-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-visit benefit, you must have had at least one prior office visit with your Network Provider within the last 12 months.

Covered E-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 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 email communications that do not qualify as E-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 and Injectable 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. 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 Urgent Care, call your Primary Care Provider first. Your Primary Care Provider or the provider-on-call is always available, day or night. He or she may either suggest that you 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
- Unexpected premature childbirth
- Acute abdominal pain
- Severe chest pain
- Serious burn
- Bleeding that does not stop
- Medically Necessary detoxification

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

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 care or to a facility specified by Providence Health Plan.

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 or our authorizing agent 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 a 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 or their authorizing agent.

4.5.5 Urgent Care

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

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

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 Network Provider and Providence Health Plan determine you need hospitalization, arrangements will be made for you to be admitted to a Network Hospital.

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

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

- Acute (inpatient) care;
- A semi-private room (unless a private room is Medically Necessary);
- Coronary care and intensive care;
- Isolation care; and
- Hospital services and supplies necessary for treatment and furnished by the Hospital, such as 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

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. 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 shown 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. (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 specified in section 4.11.

4.7.3 Outpatient Habilitative Services

Coverage is provided for Medically Necessary outpatient habilitative Services for maintenance, learning or improving skills and function for daily living. 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 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, 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* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within time frames outlined in Newborn Eligibility and Enrollment, section 8.2.4.

*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. See section 8.2.4 regarding newborn eligibility and enrollment.

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

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

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-Network.

4.9 MEDICAL SUPPLIES, MEDICAL APPLIANCES, PROSTHETIC AND ORTHOTIC DEVICES, DURABLE MEDICAL EQUIPMENT (DME) AND STATE MANDATED HEARING AID BENEFIT

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, lancets and test strips, may be purchased through Providence Health Plan Network medical supply providers or under this benefit at Network Pharmacies. Unless there is a medical exception on file, diabetes test strips are limited to products listed on the pharmacy formulary and are restricted to 100 test strips per month for insulin dependent Members and 100 test strips every three months for non-insulin dependent Members. See section 4.9.4 for coverage of diabetic equipment such as glucometers and 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 additional to any Copayment or Coinsurance for the procedure.
6. Other Medically Necessary appliances 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 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).

4.9.5 Hearing Aids and Hearing Exams

Medically Necessary external hearing aids and devices, one per ear per every four calendar years, as prescribed, fitted, and dispensed by a licensed audiologist or a hearing aid/instruments specialist, are covered under this Plan. “Hearing aids and devices” are defined as any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries and cords.

Office visits for routine hearing exams and tests, including those related to the evaluation/fitting of a hearing aid, will be payable under this Plan at the office visit benefit level as shown in your Benefit Summary.

4.9.6 Wigs

The Plan will provide coverage for one synthetic wig every calendar year for Members who have undergone chemotherapy or radiation therapy 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.

4.10 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, and day, intensive outpatient, or partial hospitalization Services. All inpatient, residential, and 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 or our authorizing agent;
- 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, neurofeedback, 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 or our authorizing agent, 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, and day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan or their authorizing agent.

Prior Authorization is required for all inpatient, residential, and 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.

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 or 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 trauma, infection or other diseases and for congenital deformities and anomalies if there is a resultant functional impairment. 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 pain, or restoring facial configuration or functions such as speech, swallowing or chewing. 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 malocclusion of the 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 shorten or lengthen the upper or lower jaw, unless related to a traumatic injury or to a neoplastic or degenerative disease; and
- Services to treat temporomandibular joint syndrome, 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 a 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-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 Network 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 Men's Elective Sterilization Services

Covered Services include men's voluntary sterilization (vasectomy). All Covered Services must be received from Qualified Providers and Facilities. Services are covered subject to the provisions of the applicable benefit, e.g., your Outpatient Surgery benefit. Services to reverse a prior sterilization procedure are not covered.

***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.

4.12.12 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. 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.

4.13 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 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 Deductible, Coinsurance, and Copayment provisions of this Plan are waived, except as follows:

The Member/recipient is responsible for the Deductible, Coinsurance or Copayment amounts, as shown in the Benefit Summary, for inpatient Hospital Services and for outpatient facility Services that are not billed as a global fee and those amounts 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 Network 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 Network Pharmacy.

You have broad access to over 26,000 Network Pharmacies and their services at discounted rates.

Providence Health Plan Network 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.

Network Pharmacies are designated as retail, preferred retail, specialty and mail-order Pharmacies. To view a list of Network 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 Network 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 the 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.
- Network 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 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 Network 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 purchase 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 Network mail-order Pharmacies. To find our Network 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 a Network 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 glucometers and 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 us 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 Network 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.

4.14.3 Prescription Drug Formulary

The Providence Health Plan Formulary is a list of Food and Drug Administration (FDA)-approved prescription generic, brand and specialty 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 added to the formulary. 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.

4.14.4 Prescription Drugs

Generic and Brand-Name 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 your brand-name benefit includes a Copayment or Coinsurance, regardless of the reason or Medical Necessity, and you request a brand-name drug, 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 in 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 Network Pharmacies as required by the ACA. Over-the-counter ACA preventive drugs received from Network Pharmacies will not be covered in full under the ACA preventive benefit without a written prescription from your Qualified Practitioner.

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; and
5. FDA-approved women's prescription contraceptives: up to 3-months initial dispensing, then up to 12-months subsequent dispensing at any of our Network Pharmacies.

Other dispensing limits may apply to certain medications requiring limited use, as determined by our medical policy. Prior Authorization is required for amounts exceeding any applicable medication dispensing limits.

4.14.6 Network 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 Network 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 there is a negative change in our Network mail-service or preferred retail Pharmacies, you will be notified of the change at least 30 days in advance.

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 therapeutic amount and must be purchased at a Network 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 Network 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.

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 for 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 hyperactivity in children and adults;
3. Drugs or medications prescribed that do not relate to the treatment of a covered illness or injury;
4. Drugs used for the treatment of fertility/infertility;
5. Fluoride, for Members over the age of 16 years old;
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, medications 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;
11. 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); and
20. Vaccines, immunizations and preventive medications solely for the purpose of travel, school, or work.

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 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 self-administered (except as provided in 4.12.8), are prescribed by you for your own benefit, or are provided or prescribed by a person who resides in your home or is a member of your family. "Member of your family" for this purpose means any person who could possibly inherit from you under the intestate succession law of any state, plus any in-law, step relative, foster parent, or domestic partner of you or of any such person;
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos and books, educational programs to which drivers are referred by the judicial system, and volunteer mutual support groups;
- Are provided to yield primarily educational outcomes. 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;
- 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 disputed 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, 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;
- 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); and
- Relate to participation in a civil revolution or riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.

The Plan does not cover:

- Charges that are in excess of Usual, Customary, and Reasonable (UCR) costs;
- Custodial Care;
- Transplants, except as provided in section 4.13;
- Services for Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, Durable Medical Equipment (DME) and Hearing Aids, 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;
- 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 and 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 unless approved by us in advance.
- Conditions for mental and nervous conditions that are specified as excluded in section 15. Definitions, for Mental Health and Substance Abuse;
- 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, 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; 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 services for the treatment of infertility, including all services related to surrogate parenting. For the purpose of this exclusion, infertility is defined as the inability to become pregnant after a year of unprotected intercourse or the inability to carry a pregnancy to term as evidenced by three consecutive spontaneous abortions;
- 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;
- Condoms and other over-the-counter birth control products; 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 parts or batteries;
- Replacement of lost or broken hearing aids;
- Repair of hearing aids are not covered. Repair needs should be discussed with your provider via your warranty period;
- Hearing aids prescribed and ordered prior to coverage, or prescribed or ordered after termination of coverage, whichever occurs first;
- Bone anchored hearing aids; and
- Hearing aids, hearing therapies and/or devices, except as provided in section 4.9.5.

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 provided in section 4.9.2.

Exclusions that apply to <u>Prescription Drugs, Medicines and Devices</u>:

- 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 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 notify the provider and the provider will have 45 days to submit the additional information. Within two days of receipt of the additional information, Providence Health Plan will complete their review and notify your provider or you of their decision. If the information is not received within 45 days, the request will be denied.
- **For 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 services that involve 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 may 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 743.847, 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

Mental Health and Substance Abuse claims should be submitted to:

PBH
PO Box 30602
Salt Lake City, UT 84130

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.

B.

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.

C. 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.

D. 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.

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

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

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.

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 Network Providers or payment for Services by Out-of-Network Providers, please ask for Providence Health Plan's help. Customer Service 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;
- Imposition of a pre-existing condition exclusion, source-of injury exclusion, network exclusion, Annual benefit limit or other limitation on otherwise Covered Services;
- Determination that a health care item or service is 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 consent 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, upon request and free of charge, have reasonable access to and copies of the documents and records, and other information relevant to our decision, including the specific internal rule, guideline, protocol, or other criterion relied upon to make an Adverse Benefit Determination.
- You can be represented by anyone of your choice at all levels of 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 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 that 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 Voluntary Second Level Internal Appeal

If you are not satisfied with the decision of the internal Appeal 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, or (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care, you may request a voluntary second level internal Appeal. If your case is eligible, it will be reviewed by Providence Health Plan's Grievance Committee. The members of the Grievance Committee are made up of individuals not involved in the initial decision to uphold an Appeal. You must submit your written request for the voluntary second level internal Appeal within 60 days of the date on the internal Grievance or Appeal decision notice or that initial decision will become final. The Grievance Committee will review all documentation presented by you and send a written explanation of its decision within 30 days of receiving your request for the voluntary second level internal Appeal.

7.2.5 External Review

If you are not satisfied with the internal Grievance or Appeal decision or the decision of the voluntary second level internal Appeal 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, or (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care, 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 voluntary second level internal 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, or (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care.**

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.**

7.2.5 How to Submit Grievances or Appeals and Request Appeal Documents

To submit your Grievance or Appeal, 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 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 on this Plan. You and your Employer must provide us 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 Employee Services

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 Customer Service.

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 his or her Spouse or Domestic Partner may elect continuation coverage for all covered Family Members. In addition, each Family Member has an independent right to elect COBRA. Thus, a Family Member may elect continuation coverage even if the 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 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 his or her covered Family Members may continue for up to 29 months from the date of the original qualifying event, or loss of coverage, whichever is later. The 29-month period applies only if the following conditions are met:

- The Social Security Administration (SSA) determines that the qualified beneficiary is disabled at any time prior to the qualifying event or during the first 60 days of COBRA continuation coverage; and
- The qualified beneficiary provides 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 that has no exclusions or limitations with respect to any pre-existing conditions. If the other plan has applicable exclusions or limitations, the COBRA continuation coverage will terminate after the exclusion or limitation no longer applies'
- The qualified beneficiary (employee, spouse, or dependent child) later becomes entitled to Medicare;
- The earliest date that the qualified beneficiary no longer qualifies for such coverage in accordance with the federal COBRA regulations; or
- The applicable maximum period of continuation coverage occurs.

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 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 NONWAIVER

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
Risk & Benefit 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 his/her 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 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**.**

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 a 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 to pay 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.

Director

Director means the director of the Oregon Department of Consumer and Business Services.

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.

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. Coverage is effective on the earlier of the first day of the next month following the completion of the Eligibility Waiting Period. 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.
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 60 days of employment 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 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.

3. 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.

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.

E-visit

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

Exclusion

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

Experimental/Investigational

Experimental/Investigational means those Services that are determined by Providence Health Plan not to be Medically Necessary or accepted medical practice in the Service Area, including Services performed for research purposes. In determining whether Services are Experimental/Investigational, Providence Health Plan will consider whether the Services are in general use in the medical community in the U.S.; whether the Services are under continued scientific testing and research; whether the Services show a demonstrable benefit for a particular illness or disease; whether they are proven to be safe and efficacious; and whether they are approved for use by appropriate governmental agencies. Providence Health Plan determines on a case-by-case basis whether the requested Services will result in greater benefits than other generally available Services, and will not approve such a request if the Service poses a significant risk to the health and safety of the Member. Providence Health Plan will retain documentation of the criteria used to define a Service deemed to be 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.

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).

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

1. The Service is medically indicated according to the following factors:
    a. The Service is necessary to diagnose or to meet the reasonable health needs of the Member;
    b. The expected health benefits from the Service are clinically significant and exceed the expected health risks by a significant margin;
    c. The Service is of demonstrable value and that value is superior to other Services and to the provision of no Services; and
    d. Expected health benefits can include:
        - Increased life expectancy;
        - Improved functional capacity;
        - Prevention of complications; or
        - Relief of pain.
2. The Qualified Practitioner recommends the Service.
3. The Service is rendered in the most cost-efficient manner and type of setting consistent with nationally recognized standards of care, with consideration for potential benefits and harms to the patient.
4. The Service is consistent in type, frequency and duration with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by Providence Health Plan.

In the case of a life-threatening illness, a Service that would not meet the criteria above may be considered Medically Necessary for purposes of reimbursement, if:

- It is considered to be safe and effective as demonstrated by accepted clinical evidence reported by generally-recognized medical professionals or publications; and
- The treatment is provided in a clinically controlled research setting using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health for a life-threatening condition.

For the purpose of this exception, the term "life-threatening" means more likely than not to cause death within one year of the date of the request for diagnosis or treatment.

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.

Network Pharmacy

Network 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 Network Pharmacies:

1. Retail: a Network Pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions.
2. Preferred Retail: a Network 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 Network 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 Network Pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.

Network Provider

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 a Network Provider.

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.

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 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 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 a Network Provider, UCR means charges based on the fee that Providence Health Plan has negotiated with 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 prevalent or which would not be considered excessive in a particular case because of unusual circumstances; or
4. 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 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 a 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 a 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).

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 می‌شود، تسهیلات زبانی بصورت رایگان در دسترس شما می‌باشد. 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, 2018.

By: _____

Printed Name: _____

Title: _____

Company: _____

Date: _____

MISSION

As people of Providence,
we reveal God's love for all,
especially the poor and vulnerable,
through our compassionate service.

OUR CORE VALUES

Respect, Compassion, Justice,
Excellence, Stewardship

Administered by:

Customer Service: 503-574-7500 or 800-878-4445

Sales: 503-574-6300 or 877-245-4077

www.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.

Gregory L. Geist
Director

September 5, 2019

Water Environment Services Board
Board of County Commissioners
Clackamas County

Members of the Board:

Approval of the Utility Easement Agreement Between Water Environment Services and Portland General Electric Company, at the Tri City Water Resource Recovery Facility

Purpose/Outcomes	Approval of the Utility Easement between WES and PGE
Dollar Amount and Fiscal Impact	This is a no cost easement and has no fiscal impact.
Funding Source	N/A
Duration	This agreement would not expire
Previous Board Action/Review	None
Counsel Review	This Easement Agreement was reviewed and approved by County Counsel on August 14, 2019.
Strategic Plan Alignment	1) Build a strong Infrastructure, and ensure safe, healthy, and secure communities. 2) Enterprise Resiliency – By January, 2021, WES will have completed the TC WRRF Solids Handling Improvements Project to support the expected 20-year growth horizon.
Contact Person	Jeff Stallard, 503-572-4694
Contract No.	*N/A*

BACKGROUND:
PGE is the electric utility provider for the Tri-City Water Resource Recovery Facility. As part of the Solids Improvements Project, the primary and secondary power feeds into the facility will receive upgrades. As the design for the power feeds progressed, it was found that no easement exists for PGE's facilities on our property. Since no easement currently exists, PGE is requiring an easement be granted for their facilities on the Tri-City WRRF property.

RECOMMENDATION:
WES staff recommends the Board, acting as the governing body of Water Environment Services, approve the Utility Easement Agreement between Water Environment

Services and Portland General Electric Company, at the Tri City Water Resource Recovery Facility.

Respectfully submitted,

Greg Geist
Director, Water Environment Services

Attachments:

- Utility Easement Agreement between Water Environment Services and Portland General Electric Company, at the Tri City Water Resource Recovery Facility

After Recording Please Return To:
Portland General Electric Company
Attn: Property Services
121 SW Salmon Street, RCCB
Portland, Oregon 97204-9951

Grantor's Mailing Address:
Water Environment Services
Development Services Building
150 Beavercreek Road, Suite 430
Oregon City, OR 97045

(Space above this line for Recorder's use)

Grantor: **Water Environment Services**

Grantee: **Portland General Electric Company**

APN/APN2: 22E20 00503 / 00529814

PGE UTILITY EASEMENT

For good and valuable consideration the current receipt, reasonable equivalence, and sufficiency of which is hereby acknowledged by **WATER ENVIRONMENT SERVICES,** an ORS Chapter 190 intergovernmental entity ("**Grantor**") hereby grants, conveys and warrants to **PORTLAND GENERAL ELECTRIC COMPANY**, an Oregon corporation, and its successors and assigns ("**Grantee**"), a nonexclusive, perpetual easement and right-of-way (the "**Easement**") over, under, upon, through and across the real property situated in Clackamas County, Oregon as further described in Exhibit "A" attached hereto (the "**Property**").

The Easement shall affect an easement area approximately Ten (10) feet in width, extending Five (5) feet on each side of a center line of Grantee's Systems (as defined herein) located as constructed and/or to be constructed on the Property, except to the extent of those portions of the Property, if any, occupied by existing building footings, foundations, aboveground improvements and/or subsurface structures on the effective date hereof (the "**Easement Area**"). As used herein, the term "**Systems**" shall include a variable number of wires, circuits, and all appurtenances, equipment, structures, poles, guys, anchors, transformers, and facilities as Grantee deems necessary or convenient for the operation and maintenance of such Systems and for the purpose of transmission, distribution, and sale of electricity and communication.

Grantee's Rights. Grantee shall have the right to enter upon and use the Easement Area to plan, survey, construct, inspect, operate, maintain, repair, replace, improve, remove, and enlarge the Systems and the right to derive income therefrom, together with all rights, uses, and privileges directly or indirectly necessary or convenient for the full enjoyment, use, and exercise of Grantee's rights under the Easement, doing all such acts or things on the Easement Area, and all works necessary or appurtenances ancillary, including but not limited to, the right to provide, maintain, and protect quality habitat for aquatic, terrestrial, and avian wildlife, and the right of ingress to and egress from, along and upon said Easement Area and over and across the Property and Grantor's adjoining property interests, in connection with or related to all or any portion of the foregoing. Grantee shall have the right to make changes in grade, elevation or contour of the land within the Easement Area, and to cut away and keep clear, prevent the construction or placement, remove, level, and/or dispose of all obstructions, structures, natural features, trees, vegetation and/or undergrowth, on, under, along or above the Easement Area (although Grantee may leave any of the foregoing on the Easement Area), which, in the reasonable judgment of Grantee, may endanger or interfere with the efficiency, safety, and/or convenient use, enjoyment, or exercise of Grantee's rights under the Easement or which is necessary for the protection from fire, natural disaster, terrorism, theft, vandalism, and other similar hazards. All exercise of Grantee's rights must be in accordance with all applicable local, state and federal laws and regulations. No right of Grantee hereunder shall lapse or be waived in the event Grantee fails to use the Easement, or any portion thereof, on a continuous basis. During initial construction of the System and prior to any other activity that may have an adverse impact on the Grantor's ability to provide services (excepting emergency situations), Grantee shall coordinate with Grantor and ensure that no actions by the Grantee will interfere with the safe, continuing provision of wastewater treatment.

Grantor's Use. Grantor shall have the right to use the Easement Area for all purposes, provided that such use is not deemed by Grantee to interfere with the use, enjoyment, or exercise by Grantee of any rights under the Easement. If Grantee is required to modify the Easement or relocate the Easement Area or Systems because of any Grantor use of the Property or at the Grantor's request, the cost associated with such relocation or modification shall be the responsibility of Grantor. Notwithstanding the rights granted to Grantee hereunder, above-ground maintenance of the Property subject to this Easement (excluding the Systems) shall be the responsibility and at the expense of Grantor, including, but not limited to, irrigation, grass mowing, and vegetation and erosion control.

Grantor Representations and Warranties. Grantor represents, covenants, and warrants to Grantee that Grantor is lawfully seized in fee simple title to the Property; that Grantor has the legal right and authority to grant this Easement and that no other party has an ownership interest in the Property or any portion thereof (including the associated timber, water, and mineral rights) that will limit or interfere with Grantee's rights hereunder whatsoever; and that the execution and performance of this Easement by Grantor is duly authorized.

Grantee Representations and Warranties. Grantee represents, covenants, and warrants to Grantor that Grantee has the power and authority to enter into and perform under this Easement and that this Easement, when executed and delivered, shall be a valid and binding obligation of Grantee enforceable in accordance with its terms.

Required Actions/Necessary Documents. Grantor agrees to cooperate with Grantee to obtain all necessary permits, licenses and governmental action and shall sign all necessary documentation to enable Grantee the full use, enjoyment and benefit of this Easement. **Each of the foregoing shall be without further compensation to Grantor.**

Liabilities. In no event shall either party, be liable to the other party or any other person or entity 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 Easement or for any failure of performance related hereto howsoever caused, whether or not arising from either party's sole, joint or concurrent negligence.

Indemnification. Grantee and Grantor shall each indemnify, protect, defend and hold harmless the other, its heirs and assigns (each an "indemnified person") for, from and against claims, liabilities, costs and expenses resulting from any act or omission of the indemnifying party or its agents on or about the Easement. Notwithstanding the foregoing, neither party shall be liable for (and the foregoing indemnity shall not cover) any claim, damage, loss, liability, cost or expense to the extent the same resulted from the negligence or willful misconduct of any indemnified person. Grantor's indemnification obligations under this provision are subject to the limitations of the Oregon Constitution and the Oregon Tort Claims Act.

Applicable Law. This Easement shall be interpreted, construed and enforced in accordance with the law of the State of Oregon with venue for any action being in the County where the Property is located without giving effect to the conflict of law provision thereof.

Entire Agreement. This instrument, along with any exhibits and attachments or other documents affixed hereto or referred to herein, constitutes the entire agreement between Grantee and Grantor relative to the Easement. This Easement may be altered and/or revoked only by an instrument in writing signed by both Grantee and Grantor. Grantee and Grantor hereby agree that all prior written and oral agreements, understandings and/or practices relative to the Easement are superseded by this instrument. The consideration acknowledged herein is accepted by Grantor as full compensation for all rights granted Grantee pursuant hereto. This Easement may be executed in counterparts, and such counterparts together shall constitute but one original of the Easement. Each counterpart shall be equally admissible in evidence, and each original shall fully bind each party who has executed it. As used herein and where the context so requires, the singular includes the plural and all grammatical changes shall be implied to make the provisions hereof apply equally to corporations and to individuals.

This Easement shall run with the Property and shall be binding on Grantor and shall inure to the benefit of Grantee, and Grantee's successors, and assigns, as well as the tenants, sub-tenants, licensees, concessionaires, mortgagees in possession, customers, and invitees of such persons or entities. The Easement is an in-gross easement and is not appurtenant to any particular property of Grantee.

IN WITNESS WHEREOF, Grantor has executed this Easement effective as of the _____ day of _____, 20_____.

GRANTOR:

WATER ENVIRONMENT SERVICES
By: _____
Name: _____
Title: _____

ACKNOWLEDGMENT

STATE OF _____)
) ss.
COUNTY OF _____)

I certify that I know or have satisfactory evidence that _____ is the person who appeared before me, and said person acknowledged that s/he signed this instrument, on oath stated that s/he was authorized to execute the instrument as _____ of **WATER ENVIRONMENT SERVICES** and acknowledged it to be his/her free and voluntary act for the uses and purposes mentioned in the instrument.

Dated: _____, 20___.

_____
Notary Public

My commission expires: _____

EXHIBIT A
PROPERTY DESCRIPTION

A tract of land in the Hiram Straight D.L.C. #42 in Section 20, T.2 S., R.2 E., Willamette Meridian, in County of Clackamas and State of Oregon, described as follows:

Beginning at the one quarter section corner between Sections 20 and 29, T.2 S., R.2 E., Willamette Meridian, thence North 57°24'33" West 32.02 feet (Called North 58° West 49 links in previous descriptions) to a stone marked "L", which stone marks the northeast corner of the first tract described in that deed to Horace J. Eldriedge, et ux, recorded November 29, 1946, in Book 381, page 223, Deeds; thence tracing the north line of said Eldriedge tract North 84° West 39.25 feet to a point in the westerly boundary of Parcel 3 of amended complaint filed August 7, 1970, in Condemnation Suit No. 73394, State of Oregon V. William O. Moore, et al, and the TRUE PLACE OF BEGINNING of the tract herein described, thence tracing the north boundary of said Eldriedge tract North 84° West 682.65 feet to a point in the westerly line of that right of way and easement for railroad purposes as described in that deed from Corporation of Sisters of Mercy to Oregon Water Power and Railway Company, recorded April 21, 1903, in book 87, page 37, Deed Records; thence tracing said westerly line and its northerly extension northerly 795.37 feet along the arc of a curve left having a radius of 1096.28 feet and a central angle of 41°34'08", the long chord of which bears North 5°29'32" West 778.04 feet to a point of tangent; thence North 26°16'36" West (called N 26°W by a previous document in Book 52, Page 135, Deed Records) 18.82 feet, more or less, to the high water line of the left bank of the Clackamas River; thence tracing said high water line upstream (the following courses and distances inserted for area computation only) North 66°35'29" East 211.50 feet and North 78°31'17" East 235.53 feet and North 71°10'51" East 315.70 feet and North 83°43'22" East 254.07 feet and North 84°14'40" East 252.55 feet to the westerly boundary of that tract of land described in that deed to Mary Himmler recorded in Book 99, Page 259, Deed Records; thence tracing said westerly boundary South 6°06'17" West (called South 6°30' West in prior deed) 215.39 feet to the westerly boundary of Parcel 2 described in Condemnation Suit No. 73394 aforesaid; thence tracing said westerly boundary South 44°45'33" West 50.31 feet to its intersection with the westerly boundary of Parcel 3 aforesaid; thence tracing the westerly boundary of said Parcel 3 the following courses and distances; westerly along the arc of an offset spiral curve, the long chord of which bears South 74°06'37" West 183.50 feet to a point of simple curve; thence southerly

65.71 feet along the arc of a curve left having a radius of 250.99 feet and a central angle of fifteen degrees, the long chord of which bears South 49°02'23" West 65.52 feet to a point of spiral curve; thence along the arc of an offset spiral curve left, the long chord of which bears South 22°09'33" West 228.56 feet; thence South 8°27'48" West 279.64 feet; thence South 9°33'47" West 299.91 feet; thence South 11°30'47" West 21.89 feet to the TRUE PLACE OF BEGINNING, containing 19.179 acres, more or less. Bearings of this description are based upon the northerly line of the aforesaid Horace J. Eldriedge tract, as monumented by marked stones, as defining North 84° West.

WATER ENVIRONMENT SERVICES

Gregory L. Geist
Director

September 5, 2019

Water Environment Services Board
Board of County Commissioners
Clackamas County

Members of the Board:

Approval of an Intergovernmental Agreement between Water Environment Services and Clackamas Community College for Watershed Health Education Field Trips

Purpose/Outcome	Approval of an IGA between Water Environment Services ("WES") and Clackamas Community College ("CCC") for Watershed Health Education field trips.
Dollar Amount and Fiscal Impact	The Agreement proposes $35,700 annually for 3 years, for a total IGA amount of $107,100. WES has received informal commitment from local municipalities also engaged in watershed education to fund a portion of the IGA totaling approximately $2,500 annually. WES will seek out additional funding partners in future years.
Funding Source	WES Surface Water Operating fund from approved FY 19/20 budget. No County General Funds.
Duration	IGA will be in effect after both parties sign and will terminate on July 1, 2022.
Previous Board Action/Review	None
Counsel Review	This IGA was reviewed and approved by County Counsel on 8/27/19.
Strategic Plan Alignment	Supports the following key result for Watershed Protection: 50% of WES' streams are healthy. Supports the following goal for the County's Performance Clackamas goals: Honor, utilize, promote and invest in our natural resources.
Contact Person	Ron Wierenga, WES Environmental Services Manager, 503-742-4581
Contract No.	*N/A*

BACKGROUND

WES' Watershed Health Education Program is intended to instruct and motivate people to take action in their daily lives to reduce human impacts on our water resources. Permits also require WES to conduct education programs to protect water quality for public health and the environment. The Clackamas Community College Environmental Learning Center ("ELC") provides an ideal location to teach concepts of watershed science and health to students. ELC staff have the skills to develop curricula and teach them, making them an ideal partner for this program.

WES requests the approval of an Intergovernmental Agreement with Clackamas Community College to develop curriculum and provide watershed health-related educational field trips for school-aged children to the college's ELC, recruit schools from WES' service district and partner jurisdictions to participate, deliver the programs, and work with WES to provide internships to CCC

Students. The agreement also includes recognition of WES as a sponsor in one of CCC's new Ecology Professional Trainings.

RECOMMENDATION
WES staff recommends the Board, acting as the governing body of Water Environment Services, approve the IGA between Water Environment Services and Clackamas Community College.

Respectfully submitted,

Greg Geist, Director
Water Environment Services

INTERGOVERNMENTAL AGREEMENT
BETWEEN WATER ENVIRONMENT SERVICES
AND CLACKAMAS COMMUNITY COLLEGE

THIS AGREEMENT (this "Agreement") is entered into and between **Water Environment Services** ("District"), a political subdivision of the State of Oregon, and **Clackamas Community College** ("Agency"), a political subdivision 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.

Water Environment Services ("District"), has identified the need for watershed health education support throughout the surface water areas it serves. As our population grows and becomes more urbanized, our already-impacted water resources face increasing pressure and are at risk of increased degradation. When customers are motivated, they can help us both by supporting our programs and by the actions they take in their daily lives. Motivating them to do so will take a concerted effort that includes education, inspiration, and facilitating their actions. The Watershed Health Education Program ("WHEP") is intended to instruct and motivate these behaviors among District customers. Student education is one component of the WHEP focused on the school-aged audience, which requires a teaching approach such that students understand the interrelated elements of systems from ecological, economic, and community perspectives. In addition, the District is required by permits to conduct education programs to protect water quality for public health and the environment. The goal of the WHEP is to develop a community that is aware of, and cares about, watershed health and the associated effects of human activity, including K-12 students. Customers need the knowledge, skills, attitudes, motivations, and commitment to work toward reducing impacts on water resources.

The Clackamas Community College Environmental Learning Center ("ELC") provides hands-on educational programming and field trips with similar goals and is an ideal location to teach the concepts of watershed science. In addition, ELC staff have both the technical and teaching skills needed to develop curricula and to teach these concepts. Therefore, a partnership between District and the ELC is proposed to develop and implement an educational program that will meet District's needs.

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 July 1, 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 District agrees to pay Agency, from available and authorized funds, a sum not to exceed one-hundred seven thousand one hundred dollars ($107,100) for accomplishing the Work required by this Agreement.

4. **Payment.** Unless otherwise specified, the Agency shall submit quarterly invoices for Work performed and shall include the total amount billed to date by the Agency 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 Agency following the District's review and approval of invoices submitted by Agency. Agency shall not submit invoices for, and the District will not pay, any amount in excess of the maximum compensation amount set forth above. Invoices may include upfront billing for internship program and professional training sponsorships.

5. **Representations and Warranties.**
   A. *Agency Representations and Warranties*: Agency represents and warrants to District 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. *District Representations and Warranties*: District represents and warrants to Agency that District 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 District 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 District or the Agency may terminate this Agreement at any time upon thirty (30) days written notice to the other party.

   B. Either the District 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 District 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 Agency may terminate this Agreement in the event the Agency fails to receive expenditure authority sufficient to allow the Agency, 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 either the Project under this Agreement is prohibited or the Agency 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. Agency 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 Agency, its subcontractors, agents, or employees. The Agency agrees to indemnify, hold harmless and defend District and Clackamas County, and their 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 Agency or the Agency's employees, subcontractors, or agents. Agency shall not be required to indemnify District or County for any such liability arising out of wrongful acts of the District or County, their officers, elected officials, agents, employees or volunteers.

However, neither Agency nor any attorney engaged by Agency shall defend the claim in the name of District or County or any department of County, nor purport to act as legal representative of District or County or any of its departments, without first receiving from the Clackamas County Counsel's Office authority to act as legal counsel for District or County, nor shall Agency settle any claim on behalf of District or County without the approval of the Clackamas County Counsel's Office. District may, at its election and expense, assume its own defense and settlement.

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. Gail Shaloum or their designee will act as liaison for the District.

Contact Information:

Gail Shaloum, Technical Services Coordinator
Water Environment Services
150 Beavercreek Rd, Suite 430
Oregon City, OR 97045
(503) 742-4597
gshaloum@clackamas.us

Renee Harber or their designee will act as liaison for the Agency.

Contact Information:

Renee Harber, ELC Program Director
Clackamas Community College
19600 Molalla Ave.
Oregon City, OR 97045
(503) 594-3015
rharber@clackamas.edu

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 District and Clackamas County without giving effect to the conflict of law provisions thereof. Any claim between District 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 District 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 District's authorized representatives' access to the Records at reasonable times and places for purposes of examining and copying.

E. **Work Product.** Agency retains all rights to any intellectual property owned by Agency and developed independently from the Work or expressly identified as Agency intellectual property in this Agreement. Specifically, the deliverables set forth in Work Task 2 "Curriculum Development," as described in Exhibit A, shall be the exclusive property of the Agency. Agency hereby grants to District a non-exclusive, perpetual, royalty-free license to use, reproduce, distribute copies of, perform and display the materials during the term of this Agreement and exclusively for the purposes set forth in this Agreement. All other work performed under this Agreement not covered under the provisions above 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 not considered Agency intellectual property described above. On completion or termination of the Agreement, the Agency shall promptly deliver these materials to the District's Project Manager.

F. **Hazard Communication.** Reserved.

G. **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.

H. **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.

I. **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.

J. **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.

K. **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.

L. **No Third-Party Beneficiary.** Agency and District 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.

M. **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 District, which shall be granted or denied in the District's sole discretion. District's consent to any subcontract shall not relieve Agency of any of its duties or obligations under this Agreement.

N. **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.

O. **Survival.** All provisions in Sections 5, 7, and 10 (A), (C), (D), (G), (H), (I), (J), (L), (Q), (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.

P. **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.

Q. **Time is of the Essence**. Agency agrees that time is of the essence in the performance this Agreement.

R. **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.

S. **Force Majeure.** Neither Agency nor District shall be held responsible for delay or default caused by events outside of the Agency or District'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.

T. **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 District ("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.

U. **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.

Water Environment Services	**Clackamas Community College**
_____	_____
Chair, Board of County Commissioners	Alissa Mahar, Vice President of College Services
_____	8.20.19
Date	Date

Approved as to Form:

County Counsel

8/27/19

Date

Exhibit A

SCOPE OF WORK

Water Environment Services Education Provided by the Environmental Learning Center

The Environmental Learning Center (ELC) proposes to provide the following educational programs for Water Environment Services. Programs that are provided for WES will be recognized as such on the ELC website and in any related marketing materials. Also, as part of our continuous improvement efforts, we regularly collect evaluations of programming, and summaries of any effectiveness evaluations will be shared with WES.

Invoicing:

- ELC will bill WES quarterly for completed curriculum development and field trip delivery. ELC will provide a progress report meeting the IGA terms, summarizing the work completed with each invoice.
- ELC will pay for teachers' busing expenses and bill WES on a quarterly basis plus an administrative fee.
- WES will pay the ELC an annual fee at the start of the fiscal year (July) for fostering internship connections between CCC and WES.
- WES will pay up front any desired sponsorship of Ecology Professional Trainings, prior to receiving any of those sponsorship benefits.

Scope of Work

Task 1: Program Management

This includes all activities needed to administer the programs in this agreement. The ELC will track expenses, coordinate scheduling and registration, purchase supplies, update its website with program offerings, and prepare and send invoices and progress reports.

Deliverables: Website updates; Invoices & Progress Reports sent quarterly

Task 2: Curriculum Development

ELC staff will research existing curricula and either modify them, or develop new curricula for the new field trips and trainings as noted below. This will include development of supplementary educational materials.

Deliverables: Curriculum for four new field trips for K-12 children; Curriculum for Stormwater Facility Management training for professionals

Task 3: Program Marketing

Field Trips: The ELC will develop marketing materials, contact schools, explain the field trip opportunities and their benefits, and coordinate with school staff to schedule the field trips. The ELC will work with WES to identify priority schools in WES' service area. In addition, the ELC will attempt to schedule three to four classes from the Gladstone School District, and six to seven classes from schools in the Oak Lodge Water Services District (OLWSD), if OLWSD joins as a partner. WES will collect funds from Gladstone and OLWSD under a separate IGA, so the ELC will only need to bill WES.

Stormwater Facility Management: The ELC will develop marketing materials, and reach out to potential landscape and public works audiences through a variety of methods. WES will be considered a co-sponsor for this workshop.

Deliverables: Marketing materials & outreach efforts

Task 4: Program Delivery

The ELC will provide approximately 40 field trips (for about 48 classes total) for K-12 schools in the WES, Gladstone and OLWSD service areas as outlined above, and one stormwater facility management training for professionals.

Deliverables: 40 K-12 field trips; One Stormwater Facility Management training

Task 5: Internships

ELC staff will develop a standardized system for ongoing recruitment of interns for WES opportunities, and develop promotional materials in consultation with WES staff. ELC will conduct outreach to students and faculty to encourage application for these internships.

Deliverables: Promotional materials; Outreach efforts; Referral of intern candidates to WES

Task 6: Sponsorship

ELC will recognize WES as a sponsor of Ecology Professional Trainings in the following ways: acknowledgement in our newsletter, acknowledgement on our website for one academic year, and a WES employee will receive one free day of training at an ELC professional workshop. In addition, for one professional workshop of WES' choosing, 1) WES's logo will be displayed on marketing materials and the welcoming slide at the workshop, 2) WES will be acknowledged on a thanks to our sponsors sign, and 3) WES materials may be displayed on a Resource table.

Deliverables: ELC newsletter, website and workshop acknowledgment

Field Trip Programs

The Environmental Learning Center currently offers field trips for K-5 students on a variety of topics, with the goal of enriching student learning through their engagement with nature. In addition to these current offerings, the ELC proposes to create and host new field trips that align with WES's education program goals. All field trips will be structured to meet specific Next Generation Science Standards (NGSS). Students will be provided opportunities to explore, interact with, measure and create within the lush outdoor surroundings of the Environmental Learning Center, which contains both forest and wetland habitat. The variety of habitat present allows us to teach about interdependent relationships in ecosystems, water quality and stormwater management.

Our recently restored wetland, fed by underground springs and stormwater runoff from the Oregon City campus, provides critical habitat for wildlife and water quality improvement, making it the ideal location to study wetland habitat. And, as the headwaters to Newell Creek, it's also the perfect venue for watershed discussions.

Field trip offerings will include:

New Field Trip: Whose Watershed Is It? *(final title will develop out of curriculum)*
Grade Levels: K-2
Length: 2.5 hrs
Location: Environmental Learning Center
NGSS Standards Alignment: (K) Human Impacts on Earth Systems-making choices to reduce impact, (2) Shapes & kinds of land/bodies of water in an area, (K-2) Engineering Design; *K-2.ED, K-ESS2, K-ESS3, 2-ESS2-2*
Essential Question: What behaviors influence the health of our watershed?

This field trip will explore the following (details subject to change):

- Definition of a watershed & where our water comes from
- How humans impact water quality
- Defining a problem (e.g. dog poo or other pollutant)
- Creating or testing solutions/or Communicating solutions - this will have to be determined in the curriculum design process, as it depends on the amount of time available, and how engaging the activities can be. The goal is to engage kids with the outdoors as much as possible.

Approach:

- Delivery to up to 15 WES service area classes annually (up to 30 students each)
- Existing curriculum will be sought out and used when possible; modifications will be necessary to suit ELC location and to incorporate *The River Starts Here*, or other WES approved messaging.

New Field Trip: Watershed Wise *(final title will develop out of curriculum)*
Grade Levels: 3-5
Length: 2.5 hrs
Location: Environmental Learning Center
NGSS Standards Alignment: (3) Natural Hazards & steps to reduce their impacts, (4) Interpreting Earth features from maps, (5) Human Impacts on Earth Systems-ways to protect earth resources and environments; *3-ESS3-1, 4-ESS2-2, 5-ESS3-1*
Essential Questions: What land formations make up a watershed? How might humans impact the movement and quality of water in a watershed?

This field trip will explore the following (details subject to change):

- What is a watershed – exploration of patterns on the earth, and experience the concept that water flows towards and collects at the lowest point
- Human impacts on our water system/environment
- The role of wetlands in reducing the impact of floods (natural disasters) & how humans impact this by either removing or constructing wetlands
- The role of wetlands in improving water quality

Approach:

- Delivery to up to 15 WES service area classes annually (up to 30 students each)
- Existing curriculum will be sought out and used when possible; modifications will be necessary to suit ELC location and to incorporate *The River Starts Here*, or other WES approved messaging.

Existing Field Trip (currently under development): Water Quality Community Science Lab
Grade Levels: 6-8
Length: 3 hrs
Location: Environmental Learning Center
NGSS Standards Alignment: (6) Monitoring & minimizing human impact on environment, (7) Data interpretation related to how changes in an ecosystem affect populations, (8) Using evidence to construct a statement on how humans impact earth's systems; *MS-ESS3-3, MS-LS2-1, MS-LS2-4, MS-ESS3-4*
Essential Question: How is water quality impacted by the built environment and our daily actions?
Approach:

- Delivery of 2 events annually for schools in WES's service area (up to 150 students each).
- This field trip will focus on factors that influence water quality, functioning of the wetland channel and why it's important to the water quality of Newell Creek, and tools for water quality assessment. Students will gather data on-site for parameters such as water temperature, dissolved oxygen, transparency and macroinvertebrates. As community scientists, they will upload the data to an online site, so they will be able to summarize the data, and also work with previous data, tracking changes to the water quality over time.

New Field Trip: Advancing Watershed Health: Stormwater Management
Grade Levels: 9-12
Length: 1-2 hrs
Location: Clackamas Community College
NGSS Standards Alignment: Resource availability influences human activity, Technological solutions for reducing human impacts on natural systems, Evaluation of a complex real-world problem; *HS-ESS3-1, HS-ESS3-4, HS-ETS1-3*
Essential Question: How do stormwater facilities function, particularly in terms of mitigating human impacts on water quality in the watershed?
Approach:

- Delivery to 5 classes annually in WES's service area (up to 30 students each)
- Faculty from our Water & Environmental Technology (WET) program will lead students on a tour of stormwater management facilities on campus, discussing how they work and why they are important to the health of our watershed.

New Field Trip: Water Industry Career Exploration
Grade Levels: 6-8 & 9-12
Length: 2 hrs
Location: Environmental Learning Center
Essential Questions: What types of jobs exist in water technology? What types of skills and training are needed for these positions?

- Delivery to 3 AVID (Advancement Via Individual Determination) groups annually from schools in WES's service area (up to 30 students each)
- AVID is a college readiness program designed to help students develop the skills needed for success in college and careers. Career exploration is an important part of this program.
- These events will introduce middle and high school students to water quality/treatment careers via engagement with WES staff (and potentially other agencies who may decide to participate in this program).

Internship Connections

- ELC staff will develop a standardized system for ongoing recruitment of interns for WES opportunities, and develop promotion materials in consultation with WES staff.
- ELC staff will reach out to students and faculty to encourage application for these internships.
- WES will provide job descriptions for internship opportunities.
- WES will provide the application form.
- WES will screen all applications, interview candidates and hire as desired.

Professional Programs

New Program: Stormwater Facility Management
Audience: Landscape professionals, Parks maintenance, Public utilities staff, etc.
Length: 2 days
Location: Environmental Learning Center

- Delivery of program once per year.
- About half will be in the classroom, and half focused on visiting and evaluating the variety of stormwater facilities that are located on the CCC campus.
- CCC Water & Environmental Technology & WES staff would co-lead the training (possibly with NCAP or other partners), with the expectation that WES staff would lead the hands-on portion.
- WES would be listed as a co-sponsor for the program.
- Continuing Education Units available.
- Potential to turn this into a non-credit certificate program.

New Programs for Potential Sponsorship: Ecology Professional Trainings
Audience: Wetland/River scientists or engineers, Fish & Wildlife biologists, Construction managers, Environmental lawyers, etc.
Length: varies from 1-2 days
Location: Environmental Learning Center, and others off-site

- The Environmental Learning Center is offering a variety of trainings designed to support the continuing education needs of professionals who work in positions connected with environmental health. Several trainings will be offered each year on topics that have been determined to be in-demand, with a focus on providing hands-on field experience whenever possible. Sponsorship dollars will provide a means for offering reduced pricing for college students and others who lack the ability to pay full price, as well as for supporting the overall education program.
- Examples of upcoming trainings that we are currently planning: Wetland Plant ID, Field ID of Fish in the Willamette Valley, Wetland Restoration Overview, Stream-Health Survey Methodology, Field ID of Macroinvertebrates, Erosion Control, Field ID of Small Aquatic Vertebrates, Watershed Health Report Cards.
- Sponsorship is available at several levels (see attached).

Qualifications

Program Lead: Renee Harber, PhD; Program Director, Environmental Learning Center

Renee has worked in education for almost 19 years (1 year at high school, and the rest at community college). Prior to working for the ELC, she served as department chair/faculty for the Horticulture Dept. at CCC, where she taught a variety of classes, and oversaw administrative functions in the department, which included curriculum development, personnel, budget, and creation of the new Arboriculture program. She was hired to rebuild the education program at the ELC in 2017.

K-8 Field Trip Instructors & Curriculum Developers:

Instructors will be chosen from a pool of qualified part-time instructors with outdoor education experience, for example:

- Sarah Bidwell: MS in Resource Management/Environmental Education & Interpretation
- Lauren Hull: MS in Geography, Certified Master Naturalist, Play-based education training
- Clare McClellan: BS in Environmental Studies
- Michelle Scholz: MS in Teaching, BS in Zoology

HS Field Trip Instructor: Jim Nurmi, PhD; Faculty, Water Environmental & Technology at CCC

Jim has taught numerous courses related to water quality at CCC, including: Environmental Chemistry, Waterworks Operations, and Aquatic Microbiology. Before coming to CCC, he worked in research at OHSU, and has experience leading a water chemistry summer camp for middle school aged children. Jim's doctoral thesis in Environmental Science & Engineering evaluated the electrochemical properties of natural organic matter.

Stormwater Facility Instructor: Matt LaForce, PhD; Department Chair/Faculty, Water & Environmental Technology at CCC

Matt has taught numerous courses related to water quality at CCC, including: Contaminant Hydrogeology, Hydrogeology, Environmental Geology, Mathematics For Water and Wastewater Operation, Soil Science, Water and Wastewater Operations, Environmental Chemistry, and Aquatic Microbiology. Matt's doctoral thesis in Soil Chemistry evaluated the cycling of metals in mining-impacted wetlands.

Timeline

Activity	Start Date	Completion Date
Develop curriculum & materials for Stormwater Facility Management training	Jul 2019	Dec 2019
Develop system for managing bus expenses	Aug 2019	Nov 2019
Develop a plan and materials for encouraging CCC student internships at WES	Aug 2019	Sep 2019
Marketing of grades 6-8 field trips	Aug 2019	Sep 2019
Develop curriculum & materials for grades K-2 watershed field trip	Sep 2019	Feb 2020
Develop curriculum & materials for grades 3-5 watershed field trip	Sep 2019	Feb 2020
Delivery of grades 6-8 field trips	Sep 2019	ongoing
Update ELC website with program information	Oct 2019	ongoing
Marketing of Stormwater Facility training	Nov 2019	Training date
Develop program for Water Industry Career Exploration field trip	Nov 2019	Jan 2020
Marketing Water Industry Career field trip	Jan 2020	Feb 2020
Marketing of grades K-5 field trips	Jan 2020	Mar 2020
Internship outreach to CCC students & faculty	Feb 2020	throughout school year
Delivery of Stormwater Facility Management training	Winter/Spring 2020	annually
Delivery of Water Industry Career Exploration field trip	Mar 2020	ongoing
Delivery of grades K-5 field trips	Apr 2020	ongoing
Marketing of grades 9-12 field trips	Aug 2020	Sep 2020
Develop curriculum & materials for grades 9-12 watershed/stormwater field trip	Jul 2020	Sep 2020
Delivery of grades 9-12 field trips	Oct 2020	ongoing

Annual Estimated Budget

Program	Description	Cost
Busing Support for Teachers (42 buses)	The cost for a bus varies based on distance traveled, and probably by school district, so this is a very rough estimate; also, the number of buses could be reduced if a school sent 2 classes on one bus.	$12,500
New Field Trip: *Whose Watershed Is It?* (gr. K-2, 2.5 hrs)	Curriculum development Field Trip delivery (to up to 15 classes of up to 30 students)	$1500 $4500
New Field Trip: *Watershed Wise* (gr. 3-5, 2.5 hrs)	Curriculum development Field Trip delivery (to up to 15 classes of up to 30 students)	$1500 $4500
Existing Field Trip: *Water Quality Citizen Science Lab* (gr. 6-8, 3 hrs)	Field Trip delivery (to 2 groups of 60-150 students)	$3000
New Field Trip: *Advancing Watershed Health: Stormwater Management* (gr. 9-12, 2 hrs)	Curriculum development Field Trip delivery (to 5 classes of up to 30 students)	$500 $1000
New Field Trip: *Water Industry Career Exploration* (gr. 6-8 & 9-12)	Program development Field Trip delivery (to 5 classes of up to 30 students)	$800 $1200
Fostering Internship Connections	Annual expense	$1000
New Program: Stormwater Facility Management (2 days, CEUs, potential non-credit certificate)	½ Curriculum development Program delivery annually-WES staff leads about ½ of training Organization, marketing & materials partial support from WES	$1600 $0 $1600
Sponsorship of New Programs: Ecology Professional Trainings (varied topics & duration, CEUs)	Sponsorship to be determined	$500
	TOTAL	$35,700

Gregory L. Geist
Director

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of a Contract with Carollo Engineers, Inc. for the
Willamette Facilities Plan

Purpose/Outcomes	Execution of the contract between Water Environment Services and Carollo Engineers, Inc. for the Willamette Facilities Plan.
Dollar Amount and Fiscal Impact	The contract amount is not to exceed $1,670,788.00.
Funding Source	WES funds 631-01-20050-431340-W630482
Duration	Contranct execution through June 30, 2021.
Previous Board Action	None.
Strategic Plan Assignment	This project aligns with the following WES initiatives: - WES will utilize a Risk-based Asset Management Plan so that asset renewal and replacement decisions for assets will be made based on a risk-to-cost decision matrix. - By June 30, 2020, develop a 20 – year Capital Improvement Plan that will estimate cost and schedule for all major investments necessary for that time period.
Counsel Review	August 28, 2019
Contact Person	Lynne Chicoine, WES Tech Division Manager, 503-742-4559

BACKGROUND:
The goal of the Willamette Facilities Plan is to develop a 20-year capital plan that identifies improvements to the District's Kellogg Creek and Tri-Cities facilities and associated conveyance infrastructure to provide the best value to WES ratepayers by maximizing the use of existing infrastructure and optimizing system operation while continuing to protect water quality and human health and support economic development.

The facilities plan will include a detailed condition assessment of the Tri-City and Kellogg WRRFs; completion of our asset management data base for the facilities; an analysis of current and future regulatory requirements; development and evaluation of intra- and inter-facility treatment alternatives; a recommended approach and implementation plan. The project deliverables will include a comprehensive Willamette Facilities Plan (WFP) and separate facilities plans for each of the two treatment facilities, the Kellogg and Tri-City WRRFs. Each plan will effectively communicate the planning process and resulting recommended plan to stake holders. This plan, in conjunction with the previously completed Collection System Master Plan, Hoodland Master Plan and Boring and Fischer Forest Park Plans complete a comprehensive 20-year capital plan to address condition and growth needs.

PROCUREMENT PROCESS:
This project was advertised in accordance with ORS and LCRB Rules on February 25, 2019. Proposals were opened on March 28, 2019. The District received four (4) Proposals: Black &

Veatch Corporation, Carollo Engineers, Inc., HDR Engineering, Inc., and Jacobs. Upon evaluation of the submitted proposals, the Evaluation Committee recommended interviewing the top two proposers, Carollo Engineers, Inc. and Jacobs. Upon completion of the interviews, Carollo Engineers, Inc. was the highest ranking proposer and the evalution committee recommended a contract be awarded. Following award, the Project Manager entered into negotiations with Carollo Engineers, Inc. and developed a final statement of work along with final billing rates and a contract total value.

RECOMMENDATION:
Staff recommends that the Board of County Commissioners of Clackamas County, acting as the governing body of Water Environment Services, approve and execute the Contract between Water Environment Services and Carllo Engineers, Inc. for the Willamete Facilities Plan.

Respectfully submitted,

Greg Geist, Director
Water Environment Services

Placed on the BCC Agenda _____ by Procurement.

WATER ENVIRONMENT SERVICES
PERSONAL SERVICES CONTRACT
Contract #1792

This Personal Services Contract (this "Contract") is entered into between **Carollo Engineers, Inc.** ("Contractor"), and Water Environment Services, a political subdivision of the State of Oregon ("District").

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, 2021.

2. **Scope of Work.** Contractor shall provide the following personal services: **#2019-08 Willamette Facilities Plan** ("Work"), further described in **Exhibit A.**

3. **Consideration.** The District agrees to pay Contractor, from available and authorized funds, a sum not to exceed **one million six hundred seventy thousand seven hundred eighty-eight dollars ($1,670,788.00)**, for accomplishing the Work required by this Contract. Consideration rates are on a time and materials basis in accordance with the rates and costs specified in Exhibit B. If any interim payments to Contractor are made, such payments shall be made only in accordance with the schedule and requirements in Exhibit A.

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 to Contractor following the District's review and approval of invoices submitted by Contractor. Contractor shall not submit invoices for, and the District 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: Lynne Chicoine.

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 Clackamas 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, and Exhibit B.

7. **Contractor and District Contacts.**

Contractor	District
Administrator: Brian Matson	Administrator: Lynne Chicoine
Phone: 503-227-1885	Phone: 503-742-4559
Email: bmatson@carollo.com	Email: lchicoine@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. District 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 District 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 District 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 District 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 Clackamas County and the District, and their 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 District or any department of District, nor purport to act as legal representative of District or any of its departments, without first receiving from the Clackamas County Counsel's Office authority to act as legal counsel for District, nor shall Contractor settle any claim on behalf of District without the approval of the Clackamas County Counsel's Office. District 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 District 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, District 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 District 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 District 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 indicated below. Contractor shall provide proof of said insurance and name the District and Clackamas County as an additional insureds on all required liability policies. Proof of insurance and notice of any material change should be submitted to the following address: Clackamas County Procurement Division, 2051 Kaen Road, Oregon City, OR 97045 or procurement@clackamas.us.

Required - Workers Compensation: Contractor shall comply with the workers' compensation requirements in ORS 656.017, unless exempt under ORS 656.126.
☒ Required – Commercial General Liability: combined single limit, or the equivalent, of not less than $1,000,000 per occurrence, with an annual aggregate limit of $2,000,000 for Bodily Injury and Property Damage.
☒ Required – Professional Liability: combined single limit, or the equivalent, of not less than $1,000,000 per occurrence, with an annual aggregate limit of $2,000,000 for damages caused by error, omission or negligent acts.
☒ Required – Automobile Liability: combined single limit, or the equivalent, of not less than $1,000,000 per occurrence for Bodily Injury and Property Damage.

This policy(s) shall be primary insurance as respects to the District. Any insurance or self-insurance maintained by the District shall be excess and shall not contribute to it. Any obligation that District agree to a waiver of subrogation is hereby stricken.

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 21 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 District, 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 District'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 District. District and Contractor intend that such Work Product be deemed "work made for hire" of which District shall be deemed the author. If for any reason the Work Product is not deemed "work made for hire," Contractor hereby irrevocably assigns to District 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 District may reasonably request in order to fully vest such rights in District. 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, District shall have no rights in any pre-existing Contractor intellectual property provided to District by Contractor in the performance of this Contract except to copy, use and re-use any such Contractor intellectual property for District use only. If this Contract is terminated prior to completion, and the District is not in default, District, in addition to any other rights provided by this Contract, may require the Contractor to transfer and deliver all partially completed Work Product, reports or documentation that the Contractor has specifically developed or specifically acquired for the performance of this Contract.

13. **REPRESENTATIONS AND WARRANTIES.** Contractor represents and warrants to District 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, 11, 13, 14, 16, and 21, and all other rights and obligations which by their context are intended to survive. However, such expiration shall not extinguish or prejudice the District'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 District, which shall be granted or denied in the District's sole discretion. In addition to any provisions the District 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. District'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 District 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.** A) This Contract may be terminated by mutual agreement of the parties or by the District for one of the following reasons: (i) for convenience upon thirty (30) days written notice to Contractor; or (ii) at any time the District fails to receive funding, appropriations, or other expenditure authority as solely determined by the District. Upon receipt of written notice of termination from the District, Contractor shall immediately stop performance of the Work. (B) if Contractor breaches any Contract provision or is declared insolvent, District may terminate after thirty (30) days written notice with an opportunity to cure. Upon termination of this Contract, Contractor shall deliver to District all documents, information, works-in-progress and other property that are or would be deliverables had the Contract Work been completed. Upon District's request, Contractor shall surrender to anyone District designates, all documents, research, objects or other tangible things needed to complete the Work.

20. **REMEDIES.** If terminated by the District due to a breach by the Contractor, then the District 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 District, less any setoff to which the District is entitled.

21. **NO THIRD PARTY BENEFICIARIES.** District 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 District nor Contractor shall be held responsible for delay or default caused by events outside the District 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 District to enforce any provision of this Contract shall not constitute a waiver by District 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 District 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. If Contractor fails, neglects or refuses to make prompt payment of any claim for labor or services furnished to Contractor or a subcontractor by any person in connection with the Contract as such claim becomes due, the proper officer representing the District may pay such claim to the person furnishing the labor or services and charge the amount of the payment against funds due or to become due Contractor by reason of the Contract.
    f. 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 District to terminate this Contract for cause.
    g. 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. **KEY PERSONS.** Contractor acknowledges and agrees that a significant reason the District is entering into this Contract is because of the special qualifications of certain Key Persons set forth in the contract. Under this Contract, the District is engaging the expertise, experience, judgment, and personal attention of such Key Persons. Neither Contractor nor any of the Key Persons shall delegate performance of the management powers and responsibilities each such Key Person is required to provide under this Contract to any other employee or agent of the Contractor unless the District provides prior written consent to such delegation. Contractor shall not reassign or transfer a Key Person to other duties or positions such that the Key Person is no longer available to provide the District with such Key Person's services unless the District provides prior written consent to such reassignment or transfer.

28. **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.

Signature page to follow.

By their signatures below, the parties to this Contract agree to the terms, conditions, and content expressed herein.

Carollo Engineers, Inc.		Water Environment Services	
_____		_____	
Authorized Signature	Date	Chair	Date
_____		_____	
Name / Title (Printed)		Recording Secretary	
705854-93		Approved as to Form:	
Oregon Business Registry #			
FBC/Delaware		_____	
Entity Type / State of Formation		County Counsel	Date

EXHIBIT A
SCOPE OF WORK
WILLAMETTE FACILITIES PLAN

EXHIBIT B
FEE SCHEDULE

Students. The agreement also includes recognition of WES as a sponsor in one of CCC's new Ecology Professional Trainings.

RECOMMENDATION

WES staff recommends the Board, acting as the governing body of Water Environment Services, approve the IGA between Water Environment Services and Clackamas Community College.

Respectfully submitted,

Greg Geist, Director
Water Environment Services

INTERGOVERNMENTAL AGREEMENT
BETWEEN WATER ENVIRONMENT SERVICES
AND CLACKAMAS COMMUNITY COLLEGE

THIS AGREEMENT (this "Agreement") is entered into and between **Water Environment Services** ("District"), a political subdivision of the State of Oregon, and **Clackamas Community College** ("Agency"), a political subdivision 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.

Water Environment Services ("District"), has identified the need for watershed health education support throughout the surface water areas it serves. As our population grows and becomes more urbanized, our already-impacted water resources face increasing pressure and are at risk of increased degradation. When customers are motivated, they can help us both by supporting our programs and by the actions they take in their daily lives. Motivating them to do so will take a concerted effort that includes education, inspiration, and facilitating their actions. The Watershed Health Education Program ("WHEP") is intended to instruct and motivate these behaviors among District customers. Student education is one component of the WHEP focused on the school-aged audience, which requires a teaching approach such that students understand the interrelated elements of systems from ecological, economic, and community perspectives. In addition, the District is required by permits to conduct education programs to protect water quality for public health and the environment. The goal of the WHEP is to develop a community that is aware of, and cares about, watershed health and the associated effects of human activity, including K-12 students. Customers need the knowledge, skills, attitudes, motivations, and commitment to work toward reducing impacts on water resources.

The Clackamas Community College Environmental Learning Center ("ELC") provides hands-on educational programming and field trips with similar goals and is an ideal location to teach the concepts of watershed science. In addition, ELC staff have both the technical and teaching skills needed to develop curricula and to teach these concepts. Therefore, a partnership between District and the ELC is proposed to develop and implement an educational program that will meet District's needs.

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 July 1, 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 District agrees to pay Agency, from available and authorized funds, a sum not to exceed one-hundred seven thousand one hundred dollars ($107,100) for accomplishing the Work required by this Agreement.

4. **Payment.** Unless otherwise specified, the Agency shall submit quarterly invoices for Work performed and shall include the total amount billed to date by the Agency 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 Agency following the District's review and approval of invoices submitted by Agency. Agency shall not submit invoices for, and the District will not pay, any amount in excess of the maximum compensation amount set forth above. Invoices may include upfront billing for internship program and professional training sponsorships.

5. **Representations and Warranties.**
   A. *Agency Representations and Warranties*: Agency represents and warrants to District 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. *District Representations and Warranties*: District represents and warrants to Agency that District 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 District 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 District or the Agency may terminate this Agreement at any time upon thirty (30) days written notice to the other party.

   B. Either the District 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 District 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 Agency may terminate this Agreement in the event the Agency fails to receive expenditure authority sufficient to allow the Agency, 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 either the Project under this Agreement is prohibited or the Agency 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. Agency 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 Agency, its subcontractors, agents, or employees. The Agency agrees to indemnify, hold harmless and defend District and Clackamas County, and their 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 Agency or the Agency's employees, subcontractors, or agents. Agency shall not be required to indemnify District or County for any such liability arising out of wrongful acts of the District or County, their officers, elected officials, agents, employees or volunteers.

However, neither Agency nor any attorney engaged by Agency shall defend the claim in the name of District or County or any department of County, nor purport to act as legal representative of District or County or any of its departments, without first receiving from the Clackamas County Counsel's Office authority to act as legal counsel for District or County, nor shall Agency settle any claim on behalf of District or County without the approval of the Clackamas County Counsel's Office. District may, at its election and expense, assume its own defense and settlement.

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. Gail Shaloum or their designee will act as liaison for the District.

Contact Information:

Gail Shaloum, Technical Services Coordinator
Water Environment Services
150 Beavercreek Rd, Suite 430
Oregon City, OR 97045
(503) 742-4597
gshaloum@clackamas.us

Renee Harber or their designee will act as liaison for the Agency.

Contact Information:

Renee Harber, ELC Program Director
Clackamas Community College
19600 Molalla Ave.
Oregon City, OR 97045
(503) 594-3015
rharber@clackamas.edu

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 District and Clackamas County without giving effect to the conflict of law provisions thereof. Any claim between District 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 District 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 District's authorized representatives' access to the Records at reasonable times and places for purposes of examining and copying.

E. **Work Product.** Agency retains all rights to any intellectual property owned by Agency and developed independently from the Work or expressly identified as Agency intellectual property in this Agreement. Specifically, the deliverables set forth in Work Task 2 "Curriculum Development," as described in Exhibit A, shall be the exclusive property of the Agency. Agency hereby grants to District a non-exclusive, perpetual, royalty-free license to use, reproduce, distribute copies of, perform and display the materials during the term of this Agreement and exclusively for the purposes set forth in this Agreement. All other work performed under this Agreement not covered under the provisions above 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 not considered Agency intellectual property described above. On completion or termination of the Agreement, the Agency shall promptly deliver these materials to the District's Project Manager.

F. **Hazard Communication.** Reserved.

G. **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.

H. **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.

I. **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.

J. **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.

K. **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.

L. **No Third-Party Beneficiary.** Agency and District 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.

M. **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 District, which shall be granted or denied in the District's sole discretion. District's consent to any subcontract shall not relieve Agency of any of its duties or obligations under this Agreement.

N. **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.

O. **Survival.** All provisions in Sections 5, 7, and 10 (A), (C), (D), (G), (H), (I), (J), (L), (Q), (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.

P. **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.

Q. **Time is of the Essence**. Agency agrees that time is of the essence in the performance this Agreement.

R. **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.

S. **Force Majeure.** Neither Agency nor District shall be held responsible for delay or default caused by events outside of the Agency or District'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.

T. **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 District ("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.

U. **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.

Water Environment Services	**Clackamas Community College**
_____	_____
Chair, Board of County Commissioners	Alissa Mahar, Vice President of College Services
_____	8.20.19
Date	Date

Approved as to Form:

County Counsel

8/27/19

Date

Exhibit A

SCOPE OF WORK

Water Environment Services Education Provided by the Environmental Learning Center

The Environmental Learning Center (ELC) proposes to provide the following educational programs for Water Environment Services. Programs that are provided for WES will be recognized as such on the ELC website and in any related marketing materials. Also, as part of our continuous improvement efforts, we regularly collect evaluations of programming, and summaries of any effectiveness evaluations will be shared with WES.

Invoicing:

- ELC will bill WES quarterly for completed curriculum development and field trip delivery. ELC will provide a progress report meeting the IGA terms, summarizing the work completed with each invoice.
- ELC will pay for teachers' busing expenses and bill WES on a quarterly basis plus an administrative fee.
- WES will pay the ELC an annual fee at the start of the fiscal year (July) for fostering internship connections between CCC and WES.
- WES will pay up front any desired sponsorship of Ecology Professional Trainings, prior to receiving any of those sponsorship benefits.

Scope of Work

Task 1: Program Management

This includes all activities needed to administer the programs in this agreement. The ELC will track expenses, coordinate scheduling and registration, purchase supplies, update its website with program offerings, and prepare and send invoices and progress reports.

Deliverables: Website updates; Invoices & Progress Reports sent quarterly

Task 2: Curriculum Development

ELC staff will research existing curricula and either modify them, or develop new curricula for the new field trips and trainings as noted below. This will include development of supplementary educational materials.

Deliverables: Curriculum for four new field trips for K-12 children; Curriculum for Stormwater Facility Management training for professionals

Task 3: Program Marketing

Field Trips: The ELC will develop marketing materials, contact schools, explain the field trip opportunities and their benefits, and coordinate with school staff to schedule the field trips. The ELC will work with WES to identify priority schools in WES' service area. In addition, the ELC will attempt to schedule three to four classes from the Gladstone School District, and six to seven classes from schools in the Oak Lodge Water Services District (OLWSD), if OLWSD joins as a partner. WES will collect funds from Gladstone and OLWSD under a separate IGA, so the ELC will only need to bill WES.

Stormwater Facility Management: The ELC will develop marketing materials, and reach out to potential landscape and public works audiences through a variety of methods. WES will be considered a co-sponsor for this workshop.

Deliverables: Marketing materials & outreach efforts

Task 4: Program Delivery

The ELC will provide approximately 40 field trips (for about 48 classes total) for K-12 schools in the WES, Gladstone and OLWSD service areas as outlined above, and one stormwater facility management training for professionals.

Deliverables: 40 K-12 field trips; One Stormwater Facility Management training

Task 5: Internships

ELC staff will develop a standardized system for ongoing recruitment of interns for WES opportunities, and develop promotional materials in consultation with WES staff. ELC will conduct outreach to students and faculty to encourage application for these internships.

Deliverables: Promotional materials; Outreach efforts; Referral of intern candidates to WES

Task 6: Sponsorship

ELC will recognize WES as a sponsor of Ecology Professional Trainings in the following ways: acknowledgement in our newsletter, acknowledgement on our website for one academic year, and a WES employee will receive one free day of training at an ELC professional workshop. In addition, for one professional workshop of WES' choosing, 1) WES's logo will be displayed on marketing materials and the welcoming slide at the workshop, 2) WES will be acknowledged on a thanks to our sponsors sign, and 3) WES materials may be displayed on a Resource table.

Deliverables: ELC newsletter, website and workshop acknowledgment

Field Trip Programs

The Environmental Learning Center currently offers field trips for K-5 students on a variety of topics, with the goal of enriching student learning through their engagement with nature. In addition to these current offerings, the ELC proposes to create and host new field trips that align with WES's education program goals. All field trips will be structured to meet specific Next Generation Science Standards (NGSS). Students will be provided opportunities to explore, interact with, measure and create within the lush outdoor surroundings of the Environmental Learning Center, which contains both forest and wetland habitat. The variety of habitat present allows us to teach about interdependent relationships in ecosystems, water quality and stormwater management.

Our recently restored wetland, fed by underground springs and stormwater runoff from the Oregon City campus, provides critical habitat for wildlife and water quality improvement, making it the ideal location to study wetland habitat. And, as the headwaters to Newell Creek, it's also the perfect venue for watershed discussions.

Field trip offerings will include:

New Field Trip: Whose Watershed Is It? *(final title will develop out of curriculum)*
Grade Levels: K-2
Length: 2.5 hrs
Location: Environmental Learning Center
NGSS Standards Alignment: (K) Human Impacts on Earth Systems-making choices to reduce impact, (2) Shapes & kinds of land/bodies of water in an area, (K-2) Engineering Design; *K-2.ED, K-ESS2, K-ESS3, 2-ESS2-2*
Essential Question: What behaviors influence the health of our watershed?

This field trip will explore the following (details subject to change):

- Definition of a watershed & where our water comes from
- How humans impact water quality
- Defining a problem (e.g. dog poo or other pollutant)
- Creating or testing solutions/or Communicating solutions - this will have to be determined in the curriculum design process, as it depends on the amount of time available, and how engaging the activities can be. The goal is to engage kids with the outdoors as much as possible.

Approach:

- Delivery to up to 15 WES service area classes annually (up to 30 students each)
- Existing curriculum will be sought out and used when possible; modifications will be necessary to suit ELC location and to incorporate *The River Starts Here*, or other WES approved messaging.

New Field Trip: Watershed Wise *(final title will develop out of curriculum)*
Grade Levels: 3-5
Length: 2.5 hrs
Location: Environmental Learning Center
NGSS Standards Alignment: (3) Natural Hazards & steps to reduce their impacts, (4) Interpreting Earth features from maps, (5) Human Impacts on Earth Systems-ways to protect earth resources and environments; *3-ESS3-1, 4-ESS2-2, 5-ESS3-1*
Essential Questions: What land formations make up a watershed? How might humans impact the movement and quality of water in a watershed?

This field trip will explore the following (details subject to change):

- What is a watershed – exploration of patterns on the earth, and experience the concept that water flows towards and collects at the lowest point
- Human impacts on our water system/environment
- The role of wetlands in reducing the impact of floods (natural disasters) & how humans impact this by either removing or constructing wetlands
- The role of wetlands in improving water quality

Approach:

- Delivery to up to 15 WES service area classes annually (up to 30 students each)
- Existing curriculum will be sought out and used when possible; modifications will be necessary to suit ELC location and to incorporate *The River Starts Here*, or other WES approved messaging.

Existing Field Trip (currently under development): Water Quality Community Science Lab
Grade Levels: 6-8
Length: 3 hrs
Location: Environmental Learning Center
NGSS Standards Alignment: (6) Monitoring & minimizing human impact on environment, (7) Data interpretation related to how changes in an ecosystem affect populations, (8) Using evidence to construct a statement on how humans impact earth's systems; *MS-ESS3-3, MS-LS2-1, MS-LS2-4, MS-ESS3-4*
Essential Question: How is water quality impacted by the built environment and our daily actions?
Approach:

- Delivery of 2 events annually for schools in WES's service area (up to 150 students each).
- This field trip will focus on factors that influence water quality, functioning of the wetland channel and why it's important to the water quality of Newell Creek, and tools for water quality assessment. Students will gather data on-site for parameters such as water temperature, dissolved oxygen, transparency and macroinvertebrates. As community scientists, they will upload the data to an online site, so they will be able to summarize the data, and also work with previous data, tracking changes to the water quality over time.

New Field Trip: Advancing Watershed Health: Stormwater Management
Grade Levels: 9-12
Length: 1-2 hrs
Location: Clackamas Community College
NGSS Standards Alignment: Resource availability influences human activity, Technological solutions for reducing human impacts on natural systems, Evaluation of a complex real-world problem; *HS-ESS3-1, HS-ESS3-4, HS-ETS1-3*
Essential Question: How do stormwater facilities function, particularly in terms of mitigating human impacts on water quality in the watershed?
Approach:

- Delivery to 5 classes annually in WES's service area (up to 30 students each)
- Faculty from our Water & Environmental Technology (WET) program will lead students on a tour of stormwater management facilities on campus, discussing how they work and why they are important to the health of our watershed.

New Field Trip: Water Industry Career Exploration
Grade Levels: 6-8 & 9-12
Length: 2 hrs
Location: Environmental Learning Center
Essential Questions: What types of jobs exist in water technology? What types of skills and training are needed for these positions?

- Delivery to 3 AVID (Advancement Via Individual Determination) groups annually from schools in WES's service area (up to 30 students each)
- AVID is a college readiness program designed to help students develop the skills needed for success in college and careers. Career exploration is an important part of this program.
- These events will introduce middle and high school students to water quality/treatment careers via engagement with WES staff (and potentially other agencies who may decide to participate in this program).

Internship Connections

- ELC staff will develop a standardized system for ongoing recruitment of interns for WES opportunities, and develop promotion materials in consultation with WES staff.
- ELC staff will reach out to students and faculty to encourage application for these internships.
- WES will provide job descriptions for internship opportunities.
- WES will provide the application form.
- WES will screen all applications, interview candidates and hire as desired.

Professional Programs

New Program: Stormwater Facility Management
Audience: Landscape professionals, Parks maintenance, Public utilities staff, etc.
Length: 2 days
Location: Environmental Learning Center

- Delivery of program once per year.
- About half will be in the classroom, and half focused on visiting and evaluating the variety of stormwater facilities that are located on the CCC campus.
- CCC Water & Environmental Technology & WES staff would co-lead the training (possibly with NCAP or other partners), with the expectation that WES staff would lead the hands-on portion.
- WES would be listed as a co-sponsor for the program.
- Continuing Education Units available.
- Potential to turn this into a non-credit certificate program.

New Programs for Potential Sponsorship: Ecology Professional Trainings
Audience: Wetland/River scientists or engineers, Fish & Wildlife biologists, Construction managers, Environmental lawyers, etc.
Length: varies from 1-2 days
Location: Environmental Learning Center, and others off-site

- The Environmental Learning Center is offering a variety of trainings designed to support the continuing education needs of professionals who work in positions connected with environmental health. Several trainings will be offered each year on topics that have been determined to be in-demand, with a focus on providing hands-on field experience whenever possible. Sponsorship dollars will provide a means for offering reduced pricing for college students and others who lack the ability to pay full price, as well as for supporting the overall education program.
- Examples of upcoming trainings that we are currently planning: Wetland Plant ID, Field ID of Fish in the Willamette Valley, Wetland Restoration Overview, Stream-Health Survey Methodology, Field ID of Macroinvertebrates, Erosion Control, Field ID of Small Aquatic Vertebrates, Watershed Health Report Cards.
- Sponsorship is available at several levels (see attached).

Qualifications

Program Lead: Renee Harber, PhD; Program Director, Environmental Learning Center

Renee has worked in education for almost 19 years (1 year at high school, and the rest at community college). Prior to working for the ELC, she served as department chair/faculty for the Horticulture Dept. at CCC, where she taught a variety of classes, and oversaw administrative functions in the department, which included curriculum development, personnel, budget, and creation of the new Arboriculture program. She was hired to rebuild the education program at the ELC in 2017.

K-8 Field Trip Instructors & Curriculum Developers:

Instructors will be chosen from a pool of qualified part-time instructors with outdoor education experience, for example:

- Sarah Bidwell: MS in Resource Management/Environmental Education & Interpretation
- Lauren Hull: MS in Geography, Certified Master Naturalist, Play-based education training
- Clare McClellan: BS in Environmental Studies
- Michelle Scholz: MS in Teaching, BS in Zoology

HS Field Trip Instructor: Jim Nurmi, PhD; Faculty, Water Environmental & Technology at CCC

Jim has taught numerous courses related to water quality at CCC, including: Environmental Chemistry, Waterworks Operations, and Aquatic Microbiology. Before coming to CCC, he worked in research at OHSU, and has experience leading a water chemistry summer camp for middle school aged children. Jim's doctoral thesis in Environmental Science & Engineering evaluated the electrochemical properties of natural organic matter.

Stormwater Facility Instructor: Matt LaForce, PhD; Department Chair/Faculty, Water & Environmental Technology at CCC

Matt has taught numerous courses related to water quality at CCC, including: Contaminant Hydrogeology, Hydrogeology, Environmental Geology, Mathematics For Water and Wastewater Operation, Soil Science, Water and Wastewater Operations, Environmental Chemistry, and Aquatic Microbiology. Matt's doctoral thesis in Soil Chemistry evaluated the cycling of metals in mining-impacted wetlands.

Timeline

Activity	Start Date	Completion Date
Develop curriculum & materials for Stormwater Facility Management training	Jul 2019	Dec 2019
Develop system for managing bus expenses	Aug 2019	Nov 2019
Develop a plan and materials for encouraging CCC student internships at WES	Aug 2019	Sep 2019
Marketing of grades 6-8 field trips	Aug 2019	Sep 2019
Develop curriculum & materials for grades K-2 watershed field trip	Sep 2019	Feb 2020
Develop curriculum & materials for grades 3-5 watershed field trip	Sep 2019	Feb 2020
Delivery of grades 6-8 field trips	Sep 2019	ongoing
Update ELC website with program information	Oct 2019	ongoing
Marketing of Stormwater Facility training	Nov 2019	Training date
Develop program for Water Industry Career Exploration field trip	Nov 2019	Jan 2020
Marketing Water Industry Career field trip	Jan 2020	Feb 2020
Marketing of grades K-5 field trips	Jan 2020	Mar 2020
Internship outreach to CCC students & faculty	Feb 2020	throughout school year
Delivery of Stormwater Facility Management training	Winter/Spring 2020	annually
Delivery of Water Industry Career Exploration field trip	Mar 2020	ongoing
Delivery of grades K-5 field trips	Apr 2020	ongoing
Marketing of grades 9-12 field trips	Aug 2020	Sep 2020
Develop curriculum & materials for grades 9-12 watershed/stormwater field trip	Jul 2020	Sep 2020
Delivery of grades 9-12 field trips	Oct 2020	ongoing

Annual Estimated Budget

Program	Description	Cost
Busing Support for Teachers (42 buses)	The cost for a bus varies based on distance traveled, and probably by school district, so this is a very rough estimate; also, the number of buses could be reduced if a school sent 2 classes on one bus.	$12,500
New Field Trip: *Whose Watershed Is It?* (gr. K-2, 2.5 hrs)	Curriculum development Field Trip delivery (to up to 15 classes of up to 30 students)	$1500 $4500
New Field Trip: *Watershed Wise* (gr. 3-5, 2.5 hrs)	Curriculum development Field Trip delivery (to up to 15 classes of up to 30 students)	$1500 $4500
Existing Field Trip: *Water Quality Citizen Science Lab* (gr. 6-8, 3 hrs)	Field Trip delivery (to 2 groups of 60-150 students)	$3000
New Field Trip: *Advancing Watershed Health: Stormwater Management* (gr. 9-12, 2 hrs)	Curriculum development Field Trip delivery (to 5 classes of up to 30 students)	$500 $1000
New Field Trip: *Water Industry Career Exploration* (gr. 6-8 & 9-12)	Program development Field Trip delivery (to 5 classes of up to 30 students)	$800 $1200
Fostering Internship Connections	Annual expense	$1000
New Program: Stormwater Facility Management (2 days, CEUs, potential non-credit certificate)	½ Curriculum development Program delivery annually-WES staff leads about ½ of training Organization, marketing & materials partial support from WES	$1600 $0 $1600
Sponsorship of New Programs: Ecology Professional Trainings (varied topics & duration, CEUs)	Sponsorship to be determined	$500
	TOTAL	$35,700